

Effeminate Boys and Masculine Girls

*How do Norwegian teachers talk about
gender variance in children?*

By: Vivian Mari Ozalbo



Supervisor: Katrina Roen

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Abstract:

In this qualitative research, 36 Norwegian primary school teachers in Oslo and Hallingdal were invited to participate in 10 focus groups. The focus groups were semi structured around 3 vignettes concerning gender variance in children. Data was analyzed using thematic analysis. Teachers' views were analyzed deductively in relation to important current debates in the field of psychology; the role of distress, the validity of the GIDC diagnosis and competing therapeutic approaches. Emerging themes in the focus groups were rigidity of gender roles, the factor of age, thoughts about causes, and teachers own emotions. This data adds to knowledge about how teachers talk about gender variance in children, how they understand emotional distress in childhood as well how teachers' view possibilities for reducing distress. In addition to describing the views of a profession that greatly influences the emotional wellbeing of gender variant children, the data also reflects the views of Norwegian adults in general.

Keywords: gender variance, trans sexuality, transgender, teachers, Norway, focus group, qualitative research, thematic analysis.

Foreword

This thesis has been a hard process, at some points it has been draining both physically and mentally. In my academic life I don't think I have struggled quite as much and there are people who deserve a thank you for helping me through. I would not have been able to do this by myself.

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1 Introduction

From our earliest days of growing up gender is at the heart of our lives; in how we dress, talk and play. Before some children lies a clear future that will turn us into “mommies” and “daddies”. As natural and problem free as this can be for some, for others the topic of gender is a constant source of pain and conflict. Their bodies does not seem to correspond to the gender identity that they “know” in their core feels right.

Centuries of poetry speak of the valor and strength of men, and the beauty and motherly side of women. The bible starts out with two humans, Adam and Eve, the embodiment of the genders, perfectly separated into two “natural” categories. However, if we take a wider scope in examining human history we see mentions of “hermaphrodites” and the notion of the “third gender” as early as Plato’s symposium (Witten et al., 2003). If we look outside our geographical area of western societies, to the diverse cultures worldwide, we see the Hijra caste and similar groups on the Indian subcontinent often described as a “third gender”, as well as the Mahu of Hawaii, or the “two-spirits” gender identity in Native American communities, where some individuals are considered as having both genders (ibid). If we continue our exploration to include other species, similarly, we encounter a myriad of gender variance, a spectacular diversity from all-female species, hermaphrodites, to species with as many as 4 genders, where indeed “traditional” gender are in a minority (Roughgarden, 2009). Nature, it follows, isn’t as simplistic as it is portrayed. Our perception of two genders as “nature’s way” is constantly challenged from all angles, although to most people, the competing views have been next to invisible or seen as obscure curios.

Terms like transgender, transsexual or gender variant have been used to refer to those individuals that do not fit neatly into the categories of traditional binary gender. These terms are used both within a framework of gender continuum; viewing different expressions of gender as a part of healthy diversity, as well as within a framework of “abnormality” versus “normality”; where the terms are used to diagnose and sometimes pathologize individuals.

1.1 A brief history of gender variance; terms, research and discourse

In the field of psychology, gender variance has historically been seen as a mental illness for which proper diagnosis and treatment is the main focus. Historically, according to

Diamond (2004), the phenomenon did not appear clearly on the psychological horizon until the 1950's. In 1952 male born Christine Jorgensen, the patient of endocrinologist Harry Benjamin, went to Denmark and became the first person publically known to undergo "modern" sex reassignment surgery (SRS). This caused a substantial amount of controversy and publicity, and resulted in the sudden appearing of people who were asking their doctors about possibilities for similar treatment. Correspondingly this patient group was now suddenly visible on the medical community's radar (Bryant, 2006). They appeared on this radar at a time where professionals had also began to take notice of intersexed individuals; individuals born with ambiguous sexual characteristics (Diamond, 2004). At this time most professionals advocated a changing of the mind instead of the body; a debate which is still present today (Bryant, 2006). However Harry Benjamin maintained that there was an underlying somatic cause and that changing the body was the correct treatment.

In the 1960's, for a number of complex reasons, there was a spark of interest in research on feminine boys (Bryant, 2006) that resulted in a small number of articles. Although the interest, relatively speaking, was still very sparse, the articles from this decade contributed with many important terms. In 1955, Money and his colleges introduced the term "gender role", as a way of describing behaviors that display a certain gender. Stoller introduced the term "core gender identity" in 1968 (Diamond, 2004) which refers to the individuals inner feeling of gender belonging, and in the same year Green coined the term transsexualism (Bryant, 2006). Even though Green's work highlighted society's role in the rigidity of gender roles, it was also concluded that the variant individuals might grow up to be homosexuals or transsexuals, and therefore needed to be "detected and treated" (as cited in Bryant, 2006, P. 25). This was not unique to him; early research generally focused on adult outcomes (i.e. homosexuality and gender identity) with priority over, for instance, psychosocial adjustment (ibid.). It is important to that we keep in mind that at this point homosexual practice was still punishable by law in in a number of Western countries, not least of all the U.S.A. and the U.K.

A term more and more frequently used throughout the 70's was the term "transgender", coined by Virginia Prince (Diamond, 2004), which specified it as separate from transvestitism and homosexuality. Homosexuals, intersexed and transgendered individuals were to see many big changes in this decade, many of which resulted from discourse within the growing field of professionals.

The 70's saw the onset of several longitudinal studies on effeminate boys. Amongst these researchers were Reker and his associates, who, in their treatment, tried to make the children's behavior more masculine by means of behavior modifying techniques. Their research soon became source of much stern criticism and important debates; introducing alternative perspectives on gender variance as well as a focus on therapeutic shortcomings (Bryant, 2006). By now the climate around homosexual individuals was somewhat changed and critics claimed Reker's approach was oppressing towards "women, gays and all people" (Rorvik, 1975, as cited in in Bryant, 2006 P. 29).

Another important event for transgendered people happened 1977 when the organization called The Harry Benjamin International Gender Dysphoria Association (HBIGDA) was founded, inspired by the legacy of Harry Benjamin. This was professional organization devoted to the understanding and treatment of gender identity disorders, which still exists today under the name WPATH (the World Professional Association for Transgender Health). Alongside this came the appearance of similar support groups continued throughout the 80's.

As pointed out by Bryant (2006), the interest shown in publishing research describing treatments for transgendered people seemed to diminish during the course of the 80's. The answer to *how* these individuals were best treated, were as such lacking both in research as well as in the DSM-III. However, the publication of the DSM-III in 1980 is important to note as a historical landmark, as the third edition brought with it some significant changes to the previous. Homosexuality was no longer listed as a mental disorder. Additionally there were two new diagnosis referring to transgendered people; Gender Identity Disorder (GID) and Gender Identity Disorder in Children (GIDC). These diagnosis were not constructed in isolation, but rather came about as a result of a passionate discourse, over several years, between professionals of the field. This process and their joined effort culminated in a final version in 1980, which was nonetheless received with mixed response by the professional community.

1.2 Gender variance today; continuing debates

Throughout the 90's as well as currently, professionals still argue the pro's and con's with keeping the GID and GIDC diagnosis in the DSM and how to best define it (Lev, 2005; Newman, 2002, Ehrbar, 2010; Cohen-Kettenis & Pfäfflin, 2009). This is a huge debate, and the questions posed go right to the core of understanding gender variance. Should it be

approached 1) as a mental disorder to be treated psychologically, 2) a mental disorder to be treated physically, or should we 2) view it as an example of normal diversity and remove the diagnosis (Ehrbar, 2010)? Any one of these perspectives rest on differing gender systems, they each bring an array of complex consequences.

Gender variance is not visible on the body, unlike intersexuality, and there are no clear physical indicators of the disorders, and hence many scientists feel that it makes sense to diagnose this as a mental disorder (Witten et al., 2003; Griffith, 2002; Ehrbar, 2010). Since the “symptoms” are psychological by nature some feel they should be treated psychologically. Purely psychological treatment suggests that gender variance is neither “natural” nor “true”; clients perceived gender identity is a result of a mental disorder, much like perceived bodyweight in anorexia. It sends a signal to society that, in a sense, a transe identity cannot be “real” (Ehrbar, 2010). This perspective brings with it a substantial amount of stigma. Because of how the diagnosis is worded, it remains with client also after SRS. As such it is not possible to “cure” it unless you conform to your born gender. However, it can be argued that stigma comes with any mental health diagnosis, and is not per se a reason to remove the diagnosis. Additionally having a diagnosis entitles a client to mental health care and therapy (ibid). It’s argued that distress in gender variant people does *not* only stem from the surroundings, but is also inherent within the condition (ibid.).

Treating gender variance physiologically embraces a belief that some transgendered share, of being born in the “wrong body” (Roen, 2001). The surgery is seen as “correcting” the mistake that nature made. At the same time however it implicitly advocates SRS as a solution for all transgendered individuals. In this way it embraces a binary gender view and does not validate the decisions of those that do not wish to transition fully or that does not identify within the binary confines. Some even reason that if the treatment is mostly medical, then it stands to reason that the diagnosis should also be (Lev, 2005).

Those that oppose the current GID and GIDC diagnosis, argue any mental disorder has to cause psychological distress. In their view distress in gender variant people only stems from the surroundings, and is *not* inherent within the condition. As stated by Langer and Martin (2004) “Cross-gender identification may in fact be statistically deviant, but there is no evidence that it is a dysfunction” (P. 11).

If this is the case, gender variant people are part of a healthy albeit stigmatized minority group. As we transgress from a binary gender model into a multi-faceted one, gender variance is seen a part of natural variance. Transgendered people are then not male,

nor female, but rather somewhere in-between of a gender continuum. The SRS becomes a cosmetic surgery performed on healthy bodies, which is completely unnecessary. This becomes an obstacle for individuals who dearly wish to alter their body physically to reflect a male or female gender identity.

Thinking of gender this way has grown increasingly popular over the last decade (Langer & Martin, 2004; Asscheman, 2009; Benestad, 2009; Benestad, 2010; Bockting, 2008). This perspective removes transgendered people from the category of “abnormality” into “normality” and possibly greater social acceptance. At the same time, however, it fits poorly with the wishes of some transgendered people to be re-categorized as a just another “normal” male or female; indeed it questions their right to be.

As demonstrated above, there are conflicting wishes also within the community of transgendered people. One size apparently does not “fit all”. Different transgendered people naturally have their own individual theories about gender, just as scientists do. Furthermore, the questions above constitute more than a theoretical debate to them; in fact it holds great practical significance for their lives. This makes many form strong opinions about these perspectives, and advocate them according to what fits their gender theories, wishes and needs. In the case of children that are gender variant the big picture gets even more complex. The children have their own gender models in some cases, which might be similar or different to how their parents think. And finally the parents, responsible for many of the decisions made, might agree or disagree strongly in between themselves. For the therapist it becomes a matter of great importance to establish the particular “model of gender deviance” within a family (Newman, 2002).

Those researchers who do view gender variance as a disorder have additional debates about etiology, since there are few clear findings on what causes gender dysphoria. Within these professionals the nature vs. nurture debate is still alive and visible in competing theories of biological versus environmental/social etiology (Möller, Schreier, Li & Romer, 2009). As noted by Witten et al. (2003) however, not very much is known about causes of gender variance, and most results have been inconclusive. It is however acknowledged by most researchers that in all likelihood “biological, genetic, family, social, and cultural factors” (Möller et al., 2009, P. 121) all contribute to gender variance through complex interactions.

The professionals examining gender variant children face several additional challenges. Amongst the few tentative conclusions have been reached about outcomes is that a majority of gender variant children will *not* grow into transgendered adults (Drummond,

Bradley, Peterson-Badali & Zucker, 2008). In gender variant male children the majority will grow up to become homosexual (or bisexual), whilst in female gender variant children the outcome seems more equally divided between homosexual and heterosexual (Zucker, 2008b). Because of this it is of even greater importance here to correctly diagnose, so that one can hopefully separate between those who “persist” into adulthood with their cross-gender wishes and those who “desist” with such wishes. The search for predictors has of yet to show consistent factors that can be used to predict it with full certainty ahead of time (Möller et al., 2009), although some researchers have found promising results and are optimistic (Delemarre-van de Waal & Cohen-Kettenis, 2006).

The answers to the earlier questions rest on different philosophical and conceptual assumptions about sex differentiation. They result in a controversy over which treatments are better (Zucker, 2008). Clinicians debate the use of behavior modification, the extent of use of hormonal treatment, who should get the treatments and how early. The debates cause treatment preferences by the clinicians, and subsequently influence the lives of the gender variant children.

1.3 Gender variance in the media

The visibility of gender variance holds implications for both the amount of research and resources that will be directed towards helping gender variant people, as well as the degree understanding and tolerance they meet in society. From being something that was hardly mentioned or known about, gender variance is becoming steadily more visible. One way this is apparent is in the amount of attention it gets in the media, where the focus has increased over the 90's up till today. According to Benestad the increasing media exposure contributes to increasing transe-positivity (Raj, 2000 in Benestad, 2010). In the movies this increasing focus is visible with acclaimed and popular movies like “La vie en Rose” (1997), “Boys don’t cry” (1999), “Transamerica” (2005).

Transgendered people have also been visible as in commercial television as well as in the music industry. In the 1998 Eurovision song contest was won by the Israeli Dana International, who was open about being born a male and who continued to become an international success. Similarly, young performer Kim Petras from Germany has gained international fame from early age as a pop star, and is open about being one of the youngest persons to have had complete SRS. The controversial and sensationalistic reality show “There’s something about Miriam” of 2003 featured Miriam, a beautiful woman who kept the

fact that she was born male as a secret during the show. It was criticized for deceiving the male participants, and for using transgenderism as a shock factor. The contestants responded with a lawsuit following Miriam's revelation of being biologically male in the final episode. Less controversial, America's next top model (2008) featured transgendered Isis King, who finished as one of 4 finalists that season. Several talk shows have had specials that cover this topic, like the Oprah Winfrey show, the Tyra Banks show alongside news magazine programs like 20/20 with Barbara Walters (Zucker, 2008b). The TV coverage has varying complexity and varying degree of sensationalism. Whether the aim is to educate or to entertain there is no doubt that many of these shows, with their substantial amount of viewers, bring their version of the topic to public's awareness.

In the internet community, the YouTube channel "Trannystar Galactica", started in 2008, is a big collaboration between transgendered YouTubers. The videos are made from gender variant people's own perspective, without having to deal with moneymaking or concern about number of viewers. In their videos the transgendered individuals answer questions from viewers, share their lives and discuss topics they are passionate. The channel has more than 1,4 million views and 5000 subscriber (as of 10th of October, 2011).

1.4 Cultural differences

The state and society will greatly decide everyday life for a gender variant child or adult. This applies to rules and rights given by legislations, the availability of support groups and financial resources, the standards for medical treatment, as well as to the degree of tolerance the gender variant child will meet. Gender roles in each culture vary, and so do the potential sanctions or rewards to those who break them.

The strictness of gender roles reflects in variations of prevalence, as well as the sex ratio of referral to psychological services (Möller et al., 2009). Arguably, this could be said to reflect genuine differences across cultures, but it is far more likely to mirror the degree of flexibility in gender roles within any given culture. What has been considered gender "appropriate" behaviors, occupations or clothing in our western culture has, after all, gone through many changes at a rapid rate. These societal changes have, in our case, lessened the differences between male and female gender roles as well as the rigidity of what is considered "normal" behavior within one gender. If gender roles are very rigid the referral rates increase as more people fall outside the defined roles. As an ultimate consequence: where you are born can determine whether you will be diagnosed with the mental disorder GID/GIDC or not.

As a result of this, a handful of studies have examined cultural differences (Cohen-Kettenis, Owen, Kaijser, Bradley & Zucker, 2003; Witten et al., 2003). As found by several anthropological and sociological studies, there is substantial cultural variation in attitudes towards gender variance and in how gender is perceived (Newman, 2002). Newman (2002) further points out that because gender systems show both cultural and historical variation “an understanding of cultural context is important in the clinical assessment of a typical gender development and challenges current models of sex and gender” (P. 352). Meeting the demands of a focus on cultural context, we now turn our attention to Norway.

1.5 Gender variance in Norway

Norway is, by many, recognized as a liberal country relatively speaking. One example of this is visible from legislations towards homosexuality, where this can be said to represent a widening acceptance of gender differentiation (Almås & Benestad, 2004). In a cross cultural study on attitudes towards sexuality (Widmer, Treas & Newcomb, 1998) Norway was described as one of the countries with highest acceptance for homosexuality. Second only to Denmark, Norway was early with recognizing same-sex marriages, in 1993 (Rydström, 2008). Currently same-sex marriage is only recognized in 10 countries worldwide, and within this group are all the Scandinavian countries. Norway was also amongst the first countries legislate anti-discrimination laws protecting homosexual individuals as well as abolishing all anti-homosexual legislations (Bolton, 1994). Norway appears to often be amongst the first countries in passing laws that towards acceptance and support of minority groups; sending a clear message about appreciating diversity.

These attitudes might explain in part why Norway is described by Witten et al. (2003) as having a “great deal of respect for otherness” (P. 227). They further claim that the Norwegian society lets “its members explore the diversities of gender” (P. 227) and that it is a society with little discrimination against transgendered persons. According to the authors there is a rapid change in thinking about diversity, where new insights are replacing old ones. What causes this openness? Two likely attributing factors are the flexibility of gender roles and the visibility of gender variance.

Taking a look at gender roles in Norway we see that Norway was amongst the first (1913) in passing laws securing women a right to vote (Hausmann, Tyson & Zahidi, 2010). Historically a tradition of gender equality can be seen all the way throughout Scandinavia (ibid.). Compared to many other nations the gap between the genders appears smaller. Today

Norway scored second in measures of gender equality on the 2010 worldwide annual report from the World Economic Forums, topping the list together with many other Scandinavian countries. The wish for equality in parenthood has also been reflected in policies concerning paid parental leave. Part of the leave is set aside for the father, encouraging fathers to spend time home with their babies (Duvander, Lappegård & Andersson, 2010). Greater flexibility of gender roles will make more people fit within the norms, and in Norway there seems to be a wide repertoire of gender “appropriate” behaviors, and many ways to be a man or woman. Gender equality in Norway may in this way contribute towards acceptance of the gender different.

While a study shows that gender variety in Norway has been near invisible up till the last decade, there is an increasing tendency of transgender issues becoming visible in Norwegian media (Roen, Blakar & Nafstad, 2011). The same trend of increasing visibility appears on the public scene in Norway (Witten et al., 2003; Roen et al., 2011). The documentary movie “All about my father” (2002) won many prizes both in Norway and abroad. It portrayed Norway’s most well-known transperson and sexologist, Espen Esther Benestad Pirelli. While hir (genderless contraction of his and her) has gotten a lot of publicity surrounding his person, hir has also professionally treated many gender variant children, as well as published articles advocating gender diversity and a multifaceted model. Hir being ever-present in the media, putting a face on transgenderism, has undoubtedly contributed to Norwegians openness and positivity towards this group. Further contributing to the awareness of gender variance was the recent NRK documentary called “The girls from Toten”. Airing as recent as 2010, it followed a handful of male-born adult transvestites and transgendered people; giving insight into the challenges they face with living outside of the traditional gender norms.

Turning our focus to the practical implications of being a transgendered individual in Norway we see that people who go through SRS have the right to a new birth certificate as well as social security number, and with the rights to same-sex marriage they no longer have to divorce their partner if already married (Witten et al., 2003). There are 2 organizations for transgendered people in Norway, FPE-NE and LFTS, the latter receives support from the Norwegian state. SRS can only be acquired on one hospital, Rikshospitalet in Oslo, with both surgery and convalescence being financially covered by the Norwegian state (Witten et al., 2003). According to the president of the HBRIS (Hansen, n.d), The Gender Identity Disorder clinic (formerly called “The working group for GID”) has actually existed since 1967. It is

currently an integrated part of the Psychosomatic Department of this hospital (ibid.). Hormonal treatment is available quite early in some cases, even before the age of 16, to clients who has reached the earliest signs of puberty (Tanner stage 2) (Cohen-Kettenis, Delemarre-van de Waal & Gooren, 2008). Although this treatment facility is said to follow the standards of the HBIGDA to at least an acceptable degree (Witten et al., 2003), some critics have argued, however, that in dealing with children and adolescents that display transgendered feelings and behaviors, very little help is provided (Almås & Benestad, 2004)

With regards to our previous 3 ways of approaching gender variance, (a mental disorder to be treated psychologically, a mental disorder to be treated physically or consider it an example of normal diversity), Norway seems to have supporters for all 3 positions, with a possible slight incline for the second. The recent seminar held by HBRS (Harry Benjamin Resource Centre), part of LFTS, entitled “The right to be woman and men – not just a diagnosis” focused on post-surgical identities as “man” and “woman”, as well as a seemingly univocal presentation of the “wrong body” perspective. This suggests a marked support for the perspective of viewing GID as a something to be treated physiologically (Roen et al., 2011). However articles by Benestad (Benestad 2009; Benestad 2010) and others, also suggest growing support for a multifaceted model and a perspective of transgenderism as normal diversity.

1.6 How do Norwegian teachers talk about gender variance in children?

As I turn to the focus of my thesis I acknowledge the importance of exploring the topic of childhood gender variance in Norway and the attitudes towards it. As a source of data I have chosen to focus on primary school teachers, since teachers and parents are presumably the first adults to recognize and respond to the gender non-conforming behavior. While parents get an in-depth look into the internal struggle of their gender variant child, teachers view these children on everyday basis in the broader context of interacting with their peers. The teachers can be said to have, in this perspective, the opportunity to observe and interact with these children in their complete environments. They assuredly have differing extent of emotional involvement with each individual child, but are exposed to a wide variance of different children. They are role models that interact with both the gender conformative and

the gender non-conforming child at the same time, often moderating between them and signaling their own attitudes.

I find it interesting as a group to look at these teachers as a first line of informal “interventions”. Exploring the attitudes, thoughts and perceptions of this group, is also likely to shed light on attitudes in society at large. In my thesis I aim to explore the topics that have been roughly outlined in this introduction. Amongst others, I aim to examine underlying gender theories, how gender variance should be defined, theories and thoughts about causes as well as preferred treatment by looking at their debates, thoughts and emotional responses. Through thematic analysis we take a closer look at factors like distress, age and gender roles and examine how these influence thinking about gender variance. Further I wish to look at their perspectives on current debates in the field of research on gender variant children.

My research question is

How do Norwegian teachers talk about gender variance in children?

- 1) What understandings of childhood emotional distress emerge through their talk?
- 2) What possibilities for reducing distress do these understandings lead to?

2 Methods

2.1 Methodological choices

In finding appropriate methods for my research, my first observation was that the theme of gender and gender views is a somewhat intangible one. Concepts with this degree of complexity do not seem easy to quantify, as one is likely to lose a lot of the phenomenon's complexity. I wished for teachers to reflect around this subject and wanted to see it from their perspective as much as possible, which strongly suggested the using qualitative research. There were many indicators that a qualitative approach was right for this theme. Mack, Woodsong, MacQueen, Guest and Namey (2005) suggest that qualitative methods have a role in making sense of complex topics and that they will provoke answers that are culturally meaningful, rich and explanatory. This fitted nicely with the type of data I required to shed light on my thesis. Qualitative research, according to the authors, provides "information about the 'human' side of an issue ... the often contradictory behaviors, beliefs, opinions, emotions, and relationships of individuals" (P. 1).

The choice of using focus groups as collection method seemed natural from the onset of designing the research. The choice was made on grounds of 1) group setting being the more "realistic" setting, 2) identifying group norms and processes, 3) gaining understandings about cultural and social norms and 4) generating a wide range of opinions.

When thinking about how teachers most usually encounter gender variant children I assume that they will usually be talking about and reflecting about it in groups with colleagues rather than try to tackle the potential challenges individually. This assumption was confirmed by explicit statements in the focus groups (Participant A & D, Focus group 1;; Participant G & E, Focus group 2; Participant J, L & Q, Focus group 4; Participant R, Focus group 5; Participant AC, Focus group 7). Most likely their opinions do not appear in a vacuum, but rather as emerge as a result of the group dynamics. Collecting data from a group, as opposed to individual interviews, might therefore be considered a more realistic setting with respect to how it is encountered in real life.

Focus groups have as a benefit that they can identify existing group norms. It allows for processes where the teachers' views are formulated and reformulated, questioned, debated and possibly moderated or polarized in the group. In talking to colleagues the teachers will find ways of presenting and arguing their views according to the norm in the group and

political correctness. They also have the chance to challenge each other and present alternative views.

Gender roles are socially constructed and culturally specific, and by using focus groups I am likely to get a broad understanding of the social and cultural norms, which, as argued in the introduction, are so vital when it comes to thinking about gender variance.

Additionally, focus groups are described as appropriate for accessing and stimulating a *variety* of opinions (Mack et al., 2005). It is likely to access a broad range of views on a specific topic rather than a single person's undisputed opinion (ibid). These are some of the reasons behind my decision on using the form of focus groups to generate data.

I spent some time choosing what method of analysis I wanted to use on the data. Different alternatives methods, like discourse analysis or grounded theory were also candidates before I landed on thematic analysis and I have no doubt that using these methods might also have given interesting insights. I had recently read and enjoyed an article by Wren (2002), which uses grounded theory, and was leaning towards this, when I was introduced to the article by Braun and Clarke (2006). Their article outlines the benefits of thematic analysis, as well as providing a comprehensible guide. Pointing out the similarities to grounded theory it was also noted that thematic analysis is a good choice for novices in research, and one of the first methods a qualitative researcher should learn (ibid.). The method is also noted for capturing unanticipated insights. Acknowledging that I am a novice in this field, and that I wished open for unanticipated insights, this method seemed suitable. This method is applicable to a wide range of qualitative research regardless of theoretical or epistemological position, unlike grounded theory which is bound to a theoretical framework. After talking this over with my thesis supervisor I landed on choosing thematic analysis.

I consider my research as a part of a constructionist paradigm. Described in former paragraphs, teachers are likely to construct their beliefs in accordance to each other and how they wish to present themselves. This is a process they may be more or less consciously aware of. Rather than interpreting the statements made by these teachers in terms of being an absolute "truth", I view them as the teachers' attempts to make sense of themselves and their opinions. I am in no way claiming that the statements in the result section is *the* perspective of teachers' views on gender variance, but rather I hope that it will be adding to the knowledge and offering additional insight.

My approach was mainly inductive (bottom-up), but there were also elements of deductive thematic analysis. With regards to my research questions, for instance concerning

the role of distress and the teachers' perspectives on two different therapeutic approaches, I was looking for data addressing these specific themes. In the chapter about focus groups by Mack et al. (2005) it is noted that "transcripts are coded according to participants' responses to each question *and/or* [italics added] to the most salient themes emerging across the set of focus groups" (P. 52), and as such this combination is obviously not a novel idea.

In my methodology I hope to have made choices that are most likely to fit such a complex theme. Combining focus group as collection method with thematic analysis as analysis method, my hopes were to gather a data corpus that was rich, complex and detailed and that includes contextual, cultural and interpersonal factors. Out of this data corpus I hope to have provided a rich, coherent description of some of the themes that appeared through the analysis.

2.2 Research process

2.2.1 Participants and recruitment

The targeted participants were teachers in Oslo or Hallingdal who worked currently with children at primary school level or that otherwise felt they had experience with children around 11 years old. I chose to get groups from both a city and a rural area to prevent any findings from being too place-specific, and hypothesizing that it would generate a more varied set of ideas. The decision of using Hallingdal as the rural location was made for practical reasons since I have contacts in this area.

My recruitment process involved finding contact information and then contacting all schools in Oslo and Hallingdal. First contact was by letter. The letter outlined my research, why this topic is of relevance and that I was requesting their participation. I followed this up with phone calls made to each school principal, and subsequent contact by e-mail with the schools that had not yet declined. The recipients contacted their teachers personally or through e-mail and tried to gather participants. Participants were able to contact me with any questions via phone or e-mail. Date and time was set via e-mail, while the teachers arranged for a room where the meeting could take place. All focus groups took place at the individual schools. Approval from the Norwegian Social Science Data Services (NSD) was obtained prior to the first focus group meeting via e-mail.

Of a total of 36 participants there were 6 male and 30 female teachers, a ratio that is not surprising since females dominate the workforce in primal school teachers. As planned I

was able to gather 10 groups, 5 in Oslo and 5 in Hallingdal. My ideal number of participants in each group was 4-5, but for various reasons I ended up having 4 groups outside this norm: 2 of which had 2-3 participants and 2 groups with 6-8 participants. There was a tendency in the groups with fewer participants to have a more equal distribution of talking than in the larger groups, however both gave interesting insight. All groups worked mainly with pupils within the approximate age group of 11 years old, with the exception of one group, which worked with slightly older pupils.

2.2.2 Materials

Prior to the focus group, I designed a qualitative semi-structured interview guide (appendix 1), vignettes (appendix 2) as well as a consent form, which I brought along to the focus groups. The interview guide included an introduction, as well as 3 main parts all structured around the vignettes. Vignette 1 and 2 described a gender variant child with either considerable distress (vignette 1) or no significant signs of distress (vignette 2). Vignette 3 described to hypothetical psychologists (psychologist A and psychologist B) that represented two different psychological approaches to the treatment of gender variant children (these approaches will be described closely in the results section).

2.2.3 Collecting data

The focus groups were recorded with a digital audio recorder from the onset of each meeting. Then followed an introduction to the focus group, which included a few words about myself, the schedule of the focus groups, what the participants were expected to do and a clarification of my role (mainly be as a moderator as well as keeping track of time). I encouraged them to express their opinions freely. For technical reasons they were asked to speak clearly and avoid interrupting each other, but that they did not have to follow a particular order to speak. Topics concerning confidentiality and anonymity, as well as data storage, were addressed and the participants agreed verbally to keep the anonymity of the group meeting towards outsiders. They were handed a consent form which they signed before I collected them. Finally I gave a brief outline of the topic of gender variance.

After the introduction they read the first vignette. They talked about their initial impressions and thoughts, and when debate seemed to subside I asked a couple of open follow-up questions about what they would say, feel or do. I would ask for explanations as needed and encourage elaboration of certain topics; otherwise I kept a relatively passive role

as interviewer. This procedure was followed for vignette 1 and 2. In vignette 3 the follow-up questions asked for their best long term solution, as well as what they thought likely to occur if one of the 2 vignette children was to receive therapy from either of the 2 psychologists. Any time they were asked for decisions (what to do, which psychologist to choose) they were asked whether believed they would be able to reach consensus as a group.

Most focus groups lasted 60 minutes. They were concluded with a debriefing where I asked for feedback, answered questions and thanked them for their participation. Participants were informed that they could contact me through phone or e-mail with any thoughts, questions or concerns they might have (none of the participants ended up contacting me).

2.2.4 From data to analysis

The focus groups were conducted in Norwegian, and then carefully turned into written transcripts after listening to the recordings several times. Pauses in speech were coded as “..”, actions were indicated with the verb in brackets, i.e. “[interrupts]” or “[laughs]”. Quotes used in the result section, has been carefully translated to English to be as close as possible to Norwegian content. Words removed from quotations for clarity, has been marked with “[...]”. Each participant was assigned a letter or 2 letters from the Norwegian alphabet and each group assigned a number. The data and audio-files were stored on my computer, password protected, as well as on a safely stored memory stick. All personal information that can identify participants was destroyed as soon as possible and the remainder will be deleted from the hard drive when the thesis is submitted.

Through several systematic re-readings of the scripts, initial themes were developed following the procedures of thematic analysis as outlined by Braun & Clarke (2006). The analysis earlier stages included writing observations and keywords in the margins of the scripts, and this was further developed into several visual mind-maps that displayed the different themes as clustered and exploring how they seemed to relate to one another. Reconstructing these from a broader more complex representation to a more focused version, I was able to redefine the key categories into a more comprehensible whole, whose basic outline is visible in the structure of the results section.

3 Results

3.1 The factor of distress: teachers comparing the two vignettes

When I chose to involve two vignettes in the focus groups, the differences between them are of course important and will be the focus of this section. In the vignette I've chosen to call vignette 1, the child ("Oscar") has a *high level of distress*; bullied at school, self-mutilating and isolating himself. In vignette 2, the child ("Tom") shows a relatively *low level of distress*; relatively well-adjusted and content in an environment that offers support and friendship. Both "Tom" himself, his parents and surroundings seem to have somewhat accepted the situation. To sum it up the greatest difference is degree of distress; both in how they explicitly feel, as well as how the surroundings treat them and how they are behaving.

Gender dysphoria without distress does exist and needs mentioning. Cohen-Kettenis and Pfäfflin (2009) state that they often encounter applicants for sex reassignment clinically that are both employed, have functioning relationships and fulfilling social lives, but that still seek treatment because they suffer from the incongruence between their anatomic sex and gender identity. Professionals then encounter a dilemma where well-functioning gender variant clients fail to reach diagnostic criteria and therefore do not have the rights to medicinal treatment. However many clinicians solve this conundrum by seeing distress as an implicit factor within the term dysphoria (ibid.), but this in turn can cause to pathologize the gender variant individuals that do not desire treatment. As one can see the relationship between gender dysphoria and distress is a complex one where it does not seem that "one size fits all" and where different individuals indeed have very conflicting needs. The differences in how the teachers view the two vignettes can be seen as comments and explorations of dilemmas like these.

3.1.1 Intended differences; the factor of distress

The two vignettes were made with the intention to be similar to each other, albeit not identical, and all differences in the texts are meant to reflect degree of distress. Our reasoning for not making the vignettes identical was to make it easy for teachers to deal with them as two separate and real children, as opposed to constructed examples they would analyze and pick apart. We also wished to make the vignettes somewhat genuine to portray how reality is

for children like these. Distress rarely exists in a vacuum, and we did not want this to be the case here either. A survey from 2006 showed that over 50% of transgender people had experiences with bullying in school (Whittle, Turner & Al-Alami, 2007). “Oscar” (Vignette1) is likewise described as being victimized, facing verbal and also physical abuse from classmates. He also self-mutilates, which was added because it is uncommon and unlikely for extreme distress not to manifest itself behaviorally in some way. The choice of including self-mutilation in particular is based around the fact that it is quite a common manifestation of distress in children with gender dysphoria. In the London service, over 23% of the gender variant children facing puberty (aged 12 and older) admitted to having engaged in self-harm (Di Ceglie, Freedman, McPherson & Richardson, 2002) and one can only assume that the numbers are in higher. In other words, “Oscar’s” victimization and self-mutilation is intended as facets that show his distress, and chosen as common examples.

The reason I chose to look at distress as a variable is because there has been a long ongoing debate in the field of psychology about the role of distress in the diagnosis GIDC. Most diagnoses in the DSM-IV include a distress/impairment criterion (Zucker, 2006). This is common sense; in order for something to be worthy of a diagnosis it must be causing problems for *someone*. Likewise, in GID, one of the main criteria under point A is “persistent and intense distress”. The question becomes: does distress in gender variant children stem from their gender variance, or is it solely a product of society’s intolerance? Distress can be present without there being a disorder, for instance when minority groups are victimized. Facing these kinds of social reprimands obviously does not mean that there is something wrong with you. In the past, minority groups have faced social ostracism, even diagnosis labels, at one point in time, only to later become accepted and included (Bartlett et al., 2000). In this way the environment sometimes plays a huge role in the well-adjustment of minorities. What has happened is that our understandings have changed, from “there is something wrong with them” to “there was something wrong with us”. One teacher comments:

We don’t know like the background for these stories, but the environments around them here could be the reason for the different stories. Like where it happens. [...] It might be that the, that second story isn’t necessarily so much the boy himself, but the environment around him. [...] If the two had swapped places it might be that they would swap thinking as well. [...] Consider what environment you have in the class and where you live. How it influences. (Participant Y, Focus group 6)

One can ask: if society were not sanctioning these people, would there be anything at all “unhealthy” with them, i.e. would there be anything to justify being diagnosed with a mental disorder? This has parallels to the multifaceted way of thinking about gender where we move from “disorder” to “diversity”. Several psychologists have debated whether GIDC would still have any qualities of a “mental illness” or “disorder” if one removed the element of distress caused by the surroundings. Is the distress within the individual evidence of pathology, or is it a social injustice, externally imposed? (Lev, 2005) If distress is merely a response to the reaction of others, one can claim that GID does not meet DSM’s own definition of a mental disorder (Bartlett, Vasey & Bukowski, 2000) since being a target for social mistreatment does not in itself imply an underlying pathology. The following excerpt comments nicely on this issue. The teacher expresses in essence that without the hardship from the surroundings this might have been a perfectly adaptive child.

But that’s what is so.. That’s something that is such a *shame*, and so peculiar and strange, that is that two might have the very same starting point. Uhm.. It could have gone a different way, like, it might be a boy that in fact gets seen as a little special and cool and.. But it *didn’t*, that didn’t happen here. [...] If there was any support around him, he could have just been one of those special, different, effeminate boys.

(Participant AF, Focus group 7)

3.1.2 Differences between the vignettes in the words of the teachers

When comparing vignette 1 to vignette 2, teachers found many similarities, and it is important to keep in mind that the teachers often talked about these children as one. It is all the more interesting to look at the instances where teachers separated and viewed the two cases as different. In the following section we will focus primarily on these perceived differences.

Teachers were not asked to compare the two vignettes, but this was undoubtedly implicated in the questions by the structure of the interview. Since they engaged first in reading one story, then answering questions, then reading a similar story and answering the same questions it comes naturally that they spent quite some time comparing vignettes. In the last question it is also asked directly about the two psychologists fit for the individual children. When looking at differences in the statement the teachers gave, we can group them into 3 general categories: 1) the children’s individual traits/descriptions, 2) the children’s

interaction with the environment and 3) the children's future; potential outcomes or choosing courses of actions.

The children's individual traits/descriptions

Z: Seems much more secure, with himself and his own identity [...]

Ø: Isn't as frustrated, well he is frustrated but not in that kind of..

X: It doesn't seem like he is sad all day long, as much as the other, perhaps.

Ø: No. He has a solution, this one. [...] He is going to change his name and everything, he's like over there.. That other one was just sad and wanted to hurt himself
(Participants X, Ø & Z, Focus group 6)

Individual traits were the focus of the most common comparative statements in the analysis of the data. When talking about individual traits, teachers would more frequently give descriptive characteristics to the child with less distress; "Tom" (vignette 2). Teachers tended to describe him as (relative to "Oscar" in vignette 1) being more mature, more determined, happier, braver, more likely to act, more concrete in demands and further along the road to self-actualization. A main focus in descriptions seemed to lie on self-actualization. It was worded in a variety of different ways, but frequently focusing on "Tom's" relationship with himself. Viewing gender variance a self-actualization of an innate identity is, according to Vanderburgh (2009), a relatively new approach. He suggests that it is a useful conceptualization to view the child's gender identity like this. As something which "is what it is", where one encourage the child to explore and discover it rather than trying to steer the child in any particular direction. The topic of self-realization and this kind of thinking was often present in the teachers' descriptions. These descriptions could be interpreted as fitting the trend Vanderburgh describes. Amongst other things he is described as more accepting of his own identity, more sure of who he is, more secure and more insightful. In general, teachers gave rich descriptions of "Tom", filled with positive, empowering traits.

When it came to characteristics, teachers did not seem as fond of describing "Oscar" in the same plentiful way they did with "Tom". The impression one got was that teachers seemed more cautious overall in describing Oscar. They seemed more alienated by his problems and knew less how to deal with it. When "Oscar" (vignette 1) is described, it is mostly in light of his emotions; basically the factor of distress. For instance he is described as sad, going through hell, in pain, more frustrated and more distressed. As one can note these are more or less synonyms for distress. In addition he is described as less mature and more confused about what he wants. It is interesting to note that his distress gives some teachers

more doubts about his determination (Participants H, J, K & M, Focus group 3). It might be that teachers view “Oscar’s” self-destructive acts as evidence of him not accepting or agreeing with how things are, and hence see it as him being more likely to want it changed, maybe going away from his real wishes to adjust to the social norm. While Oscar’s emotions seemed to make up the most vivid impression of him, this vignette also seemed to bring out the most emotional reactions from the teachers. Statements like “Oh, that poor child! Poor child, that has to go through all of this!” (Participant G, Focus group 2) were not uncommon.

In a few groups talking about “Oscar” also inspired teachers to make spontaneous autobiographical references to their own children (Participant G, Focus group 2; Participant E, Focus group 2; Participant R & S, Focus group 5). The stories shared were not necessarily about gender variance (although some were), but this is still interesting, both because personal stories like these were an otherwise rare occurrence, and because similar stories did not appear while groups talked about “Tom”. If we look at how this contributes to the discourse, autobiographical stories about own children are almost a bold statement in itself. Sharing experiences from your personal life is considered a step away from one’s professional work role, into a more personal space. These are stories that change the atmosphere of the focus groups. The focus group becomes a space where it is allowed to elaborate on personal feelings, as well as think and react less intellectually. This could mirror their process in relating to “Oscar”. Maybe analytical and intellectual reasoning falls short in this case, and that it feels more productive and appropriate to relate to this vignette in an intuitive, emotional manner.

It is interesting that “Oscar” and “Tom” were perceived so differently based on the single factor of distress. However it might be that their focus lies on other things when they compare the two vignettes. As an example; teachers might focus on self-mutilation and interpret that as proof for underlying psychopathology. If so, they might view “Oscar” as “a child with a mental disorder”, while “Tom” is “normal” this could become the main difference they respond to. In that case, they would be responding to label of “pathology” more so than degree of distress.

The children’s interaction with the environment

As the second most prominent theme, teachers discussed differences in the environment of the two vignettes, or the child in relation to the environment. Lack of acceptance naturally causes great distress, as pointed out by Bartlett et al. (2000). Similarly,

when talking about “Oscar” (vignette 1), teachers agreed that the surroundings caused a lot of his misery. “Oscar’s” peers, and also his parents were described as less supportive (not stated in the vignette itself). When they described the environment “Oscar” lives in, the environment seemed to be treated as the main antagonist, and “Oscar’s” role became more passive one, more in line with that of a helpless victim. This is in line with the personal descriptions described in previous paragraphs. When talking about “Tom” (vignette 2) he is given more credit for his improved relationship with the surroundings; viewed as socially talented, more clear in his communicating his needs, more skilled to adjust. Teachers described the environment in “Tom’s” life as overall “better” and “more tolerant” than in “Oscar’s” case, beyond anything implied by the words in the vignettes. “Tom’s” parents are described as “more open to talking”, more “on top of things”, more “accepting”, and “healthier in their attitudes”. One teacher questioned that they might be “too ok with it” (Participant AC, Focus group 7), but other than that the teachers agreed in their praise of “Tom’s” environment.

It is notable that some used the term “luck” in the comparisons. Undeniably there is a factor of coincidence making a difference when it comes to what environment you are born into and to what extent they will support diversity. The teachers used the word while engaging in a spontaneous thought experiment that brought about some of the most interesting debates in this research. What would happen were the two children to have swapped places at birth? (Participant Y, Focus group 6, Participant AF, Focus group 7) If one looks this, it is basically a debate over what causes the differences between the children. What causes the distress; innate traits (nature) or environment (nurture)? Teachers partaking in this particular thought experiment speculated and thought aloud, asking oneself whether swapping place of birth might cause a huge difference, making “Tom” the distressed, bullied, self-mutilating child and “Oscar” the well-adjusted one. Or might the children evoke the same reactions regardless of environments? Maybe Tom’s relatively higher self-esteem makes him liked better by his surroundings (Harter, 1996). “Luck” was also used describing that the child was lucky to having those exact parents. One teacher (Participant U, Focus group 5) said jokingly that “This is where *choice* of parents makes it easier for some”, to which another teacher (Participant T, Focus group 5) laughingly replied “Yes, those lucky with the prize draw!”, both joking with the notion that one has influence on which parents one is born with. With this they are emphasizing their view on the sometimes non-existing control a gender variant child has with regards to its environment.

The significance of using the word “luck” in this context is that it makes an inadvertent comment about how randomly one’s fate might be determined; dictated by luck of the draw. This, in a way, questions the importance of the very differences outlined in the previous section (traits). Things that are decided by luck are not derived by our efforts. If luck decides the reaction from surroundings, then the children are mere protagonists; exposed to whichever surroundings they were given; having to make do with what it offers without likelihood of changing it.

The children’s future; potential outcomes or choosing courses of actions

The most clear cut differences appeared when teachers talked about different outcomes or what course of action to take. Many groups agreed that both cases needed outside help, but some teachers viewed vignette 2 as unproblematic; just “one amongst many pupils which are different” (Participant D, Focus group 1) and that they would “wait and see how it goes” before calling in professional help (Participant Æ, Focus group 6).

The outlook for “Oscar” (vignette 1) was generally viewed as less likely to be positive. Phrases as “worrying”, “not going to end well” or “pessimistic outlook” were common. There was a general agreement that “Oscar” has bigger problems, needs help more urgently and that he needs *more* support and help. It was also suggested he needed a broader specter of professionals than “Tom” does.

About “Tom” on the other hand it was stated that he might only need a slight guiding on his own journey of self-discovery, or sorting out practical options in the future. It was described as an easier case by most teachers. A couple of teachers at one school (Focus group 3) disagreed in this though, and stated out that “Tom” might demand more concrete actions from the school and the teachers. This poses more challenges for the environment. It was further suggested by this group, that there are additional dangers with “Tom”. They described “Tom” as “man of action” with very clear ideas of what he wants and needs, and they feared he might act rashly if the surroundings tries to slow him down or stop him from getting what he wants (Participant H, Focus group 3). When you know exactly what you need to be happy, it is much harder to accept that you might not get it right now (Participant J & H, Focus group 3). Although this group was a minority in not viewing “Tom” as easier to deal with, they might be addressing an important point. When minorities are no longer invisible and submissive the tension with the majority increases, and the end result might be a change in society’s thinking. While “Oscar” isolates himself with his differences, “Tom” is more

unlikely to do the same, he might want to “be himself” full visible in a gender non-conforming way. In this way he does pose a different challenge for the surroundings than “Oscar” does. The people surrounding “Tom” might have to restructure their views of what normality is, something they might be able to sidestep with “Oscar” since he is too distraught to demand it.

Puberty is challenging for children like “Tom” and “Oscar”. This assumption is backed up by the fact that there are more findings of mental health issues in boys from 12-14 than 6-11 when you look at children referred for gender issues (Coates & Person, 1985, in Vanderburgh, 2009). One group of teachers commented that unlike “Oscar”, “Tom” might have a harder time dealing with the transition into puberty (Participant X, Focus group 6); since he has had relatively few problems up till now and ergo his life is about to get a whole lot more challenging. Meanwhile “Oscar” is already going through pretty tough days pre-puberty, his level of distress is already extreme, hence he is not facing the same fall in wellbeing and well-adjustment.

When it comes to choosing courses of actions, the one question where teachers were directly asked to compare the two children was in regards to which psychologist they favored (psychologist A or B). The descriptions stated that psychologist A aims to help the child become comfortable with their born gender, changing their mind through behavior modification towards gender conformity. Psychologist B wants to help the child discover what it wants and help make transitioning easy. Curiously enough most teachers answered identically for both children on this question, even if reminded that they could differentiate. This might simply be because the teachers’ individual core values or models favor one of the therapists. These might be assumptions about how one should work with children, what humans need to be well-adjusted or models of change. The same applies if their understandings cause them to fully reject one of the psychologist, which will leave the other as the only alternative.

A few teachers did differentiate between “Oscar” and “Tom” when choosing psychologist. Some merely suggesting that the same psychologist might not be ideal for both children, or that the chemistry between child and therapist will outweigh the therapist’s methods. While there were few signs of an overall consensus, there was a vague trend of viewing psychologist A as a definite bad fit for “Tom”. Not surprising, since “Tom” is described as well-adjusted in his gender non-conforming behavior, and psychologist A would encourage him to accept his born gender. Rejecting this intervention with “Tom”, might fall

under the common sense rule of “if it isn’t broken, don’t try to fix it”. When it came to “Oscar”, however, some teachers entertained the thought of whether psychologist A might make “Oscar” fit in and interact better to peers. It is possible that the notion of “being yourself” here falls second to the need for relieving the intense distress that comes as a result of “Oscar” mismatch with his environment. The reasoning might be as follows: if one could to make “Oscar” fit in better and thereby lessen the distress, this might be worthwhile, simply to keep him alive, even if the cost is him having to “live a lie” for a while. One teacher explores the different possible choices in this manner:

The first pupil was so distressed and might not want to be how he is, right, and started to harm himself. And then behavior modification might be helpful, and “If you do like *this* then maybe [it will] become easier to be around the others” [...] While number 2 might just go to B and just be happy in his home environment and.. I don’t know. I [...] They might not need to send both to the same psychologist. (Participant Æ, Focus group 6)

The description of “Oscar” here again shows how self-mutilation can be interpreted in different ways. This teacher interprets the cutting as “Oscar” wanting his gender identity to change (rather than his body). It is used as evidence of “Oscar” wanting and needing to change his gender identity. Psychologist A can help him find ways to do that. It is worth noting that the teacher takes time to demonstrate the kind of behavior modification she feels might be helpful towards “Oscar”. In her demonstration she is using gentle “hints” and advice uttered in a nonintrusive manner. In this way she might be incorporating what she feels “Oscar” needs (i.e. conforming) and at the same time adjusting her perception of psychologist A to fit her notion of how this child should be met. For this teacher psychologist A might represent changing the child, while B represents not doing so (yet). In this manner she might be pairing the children up accordingly to her interpretation of their needs; that “Oscar” needs immediate change, while “Tom” might not.

Explicitly, teachers question whether distress is in any way inherently caused by the gender variance. They focus on the environments contribution to the children’s suffering, and by doing so they once again, inadvertently, question the validity of the GIDC diagnosis.

However, when we look at how teachers differentiate the two vignettes, we see that distress does influence how the children are perceived on many levels. Teachers’ perceptions of what is appropriate courses of action, as well as likely outcomes is also affected by perceived level of distress. Low distress is mainly interpreted positively, with “Tom” being

consistently seen in a better light than “Oscar”. For transgendered individuals this implies that the degree of distress they show will have big effect on how the surroundings view them; what kind of support they are likely to meet, and whether their feelings are likely to be validated.

3.2 Gender, gender roles and gender identities

“And what is it? What is it to be very masculine or very feminine? [...] What do we associate with it? [...] I associate one thing with it, you associate another with it, right?”

(Participant C, Focus group 1)

In the focus groups teachers often voiced critical questions or views on gender and gender roles. They voiced their thoughts on the issue in a somewhat unconfident and uncertain manner. Maybe not surprising since these are quite difficult terms and concepts, the definition of which constantly create debate also amongst psychologists. As the quote above shows teachers are well aware of the relative nature of gender roles; in no way are they templates set in stone. They are socially constructed and heavily influenced by the culture and time they exist in. Just within the last 50 years the western culture has seen rapid changes in what is considered gender appropriate behaviors for men and women. As pointed out by Vanderburgh (2009) there are very few, if any, behaviors now that are restricted to one gender solely.

3.2.1 Degree of rigidity in gender roles

Langer & Martin (2004) described that while gender identity is the private experience of one’s gender, gender roles are the public manifestation. Specifically, gender roles refer to socially ascribed characteristics and expectations; attitudes, behaviors, beliefs and values associated with being male or female in a particular culture (Glossary of terms, 2008). Being gender conforming or gender variant has to do with how much you abide by the standards that gender roles dictate. However, different cultures and times change the content of gender roles, the importance of abiding, and the consequences to those that don’t.

“Since culture and society have a foul tendency to sanction negatively gendered expressions that do not conform to the binary, all therapeutic work focused only on the individual may be futile, because the individual will not be gender affirmed by the surroundings.” (Benestad, 2010, P. 225) As Benestad points out here, without the support of the surroundings the individual will not succeed. One of the most commonly addressed topics

about gender was about the rigidity of gender roles at the teacher's school; how much opportunity does an individual have to live out non-conforming gender expressions, without being sanctioned? This is important because it dictates how teachers view the possibility for the vignette children to "be themselves". Their degree of optimism about someone living out gender non-conformity, while still maintaining a good social outcome, will rely on this. Therefore it will also influence the degree to which teachers encourage the children to "be themselves". Teachers differed in how rigidly they perceived the standard for gender roles at the place they work. This may reflect real differences between schools, the teacher's personal worldview or the narrative that the teachers on a particular school have developed over time about how their school is.

Some described their district as having a clear standard for what little boys are allowed to do and not, with regards to gender "appropriateness", and where you cannot diverge from that without facing serious social consequence. "Particularly in the class that I have right now. If anyone of them were to.. They would figure out pretty soon that *that* is something they should keep to themselves." (Participants N, Focus group 4).

In other focus groups they questioned the rigidity of gender roles, describing them as relative and open, and stating that "there is plenty of room for that [gender variance] here" (Participant X & Æ, Focus group 6). There was little consensus on status quo, but a commonly expressed wish for gender roles to be very flexible with plenty of room for diversity. Concerning gender roles, two sub-topics appeared, both scrutinizing the perceived status quo of gender roles at the teachers' school. One was regarding whether gender roles are more or less fixed now than before, the other was whether the male gender role is equally fixed as the female gender role.

3.2.2 Perceived changes in gender roles over time

When teachers compared rigidity in gender roles before versus now, quite opposite opinions arose. This first excerpt shows how some teachers feel gender roles have become more explicit and visible in the everyday life of pupils today.

"Because children are almost.. [...] they aren't more "gendered", but like.. [...] There exists much more gender specific clothing now than when I was a child; whilst me and my brother we could pass on and swap [...] it was unheard of that a sweater would not be ok for him to wear because it had been mine, kind of. That was simply not a topic!

[...] They cut the same haircut on all of us kids. [laughs].” (Participants AC Focus group 7)

The teachers in this focus group described changes that were related to changes in the market. Producers invent new niches (for instance gender-appropriate pencil cases) and hence inventing the “need” for products like this. As a result gender tags appear where gender is irrelevant. In today’s society, creating and showing your unique identity is viewed as important, and these products become “tools” to show who you are. As result there is a wild variety of “girl products” and “boy products” compared to before.

Other teachers were of the opposite view, namely that gender roles are less strict now. They felt their school and community had become more relaxed towards gender roles. Boys were to a larger extent allowed to participate in girl’s activities without being scowled upon (Participants A, C & D, Focus group 1). One teacher described it as a stringent set of rules that has “loosened”, noticeably, even during the last 3-4 years (Participant C, Focus group 1). She suggested that this has to do with the dads getting “softer” and more “in touch with their feminine sides”. As one teacher stated “there are many ways to be a boy” (Participant AC, Focus group 7) One participant concluded that with so many things “heading the wrong way in today’s society”, it is nice seeing that at least *this* is on the right track (Participant C, Focus group 1). These teachers focus on the modernization of the male’s role. With increased equality between genders, females have gained access on previously male dominated fields. This results in an overlap of the female versus male gender role, thus both genders reframe what makes out their “core”. For the western male it is no longer sufficient to be “breadwinner” or “muscle power”, hence a new male gender role appears, restructured around different values than before, while both gender roles have become more flexible.

We can conclude that teachers’ views on whether or not we are moving towards more or less stereotyped gender roles is not as uniform as one might think. These perceptions are significant because they color the teachers expectations of what the future holds.

If gender roles are perceived as becoming increasingly rigid, this might make teachers weary about encouraging any form of gender expression that is not conforming to the “norms”. If society is perceived as becoming more lenient towards gender variance, this might make teachers expect more positive outcomes and therefore encourage gender variant children to “be themselves” openly. It also impacts views on psychological approaches in different ways. If we consider SRS; teachers of this view might support it more wholeheartedly, because the future has less of a focus on “passing”. Or they might take a

multi-faceted perspective where surgery should not be necessary because society has room for many colorful expressions of gender. Or, contra intuitively, it might make them encourage the children to hold off on transitioning because a better attitude in society lies “right around the corner”. In conclusion; thoughts about developing trends in gender roles is not agreed upon, but can influence teachers’ views on when the children should come out (sooner / later), to what extent they should be open about it and whether they feel there is hope for them in the future.

3.2.3 Perceived rigidity of the male versus the female gender role

Within the field of gender variance, differences between gender roles have been the focus of much attention; i.e differences in referral rates to GIDC clinics and differences in diagnostic criteria of GIDC (Zucker, 2004; Zucker, Bradley & Sanikhani, 1997; Langer & Martin, 2004). Within the focus groups one question that often arose spontaneously was whether it is equally strict for both sexes. “The template is not as clear cut for girls, but ‘boys shall be boys’.” (Participant N, Focus group 4). Teachers seemed to agree on an intuitive level that female gender roles are far more lenient and flexible than the template for males, with no one voicing any contradictory opinions. They were curious as what causes this difference. One teacher had a theory that male gender roles are stricter because the male peers are more rigidly enforcing gender “appropriateness” in behavior, bullying the males that break the rules for gender-conforming. The teacher suggests that observing non-conforming behavior makes males feel emotionally uncomfortable or “threatened”. It initiates a fear response in them, possibly due to homophobia that seems to be present from quite early on (Participant AH, Focus group 8).

This theory is interesting in light of a study on victimization of non-identified gay male youth (Carragher & Rivers, 2002). Factors that single out the young men for being victimized are; disliking sports, social withdrawal or shyness, and being perceived as effeminate (Waldo, Hesson-McInnis & D’Augelli, 1998, as cited in Carragher & Rivers, 2002). These characteristics fit well on many gender variant males. Perceived sexual orientation also plays a part in making the peers feel threatened. It triggers homophobia and leads to bullying (Carragher & Rivers, 2002). As such the hypothesis of participant AH seems very well in line with psychological research. Unfortunately this does not answer the question of why it is not the case with girls.

Sex ratios of referred children with GIDC, however, might shed light on this question. In most studies, boys outnumber girls 3 to 5 times (Asscheman, 2009). One could initially suspect that biologically male children with GIDC are more common than females. However, this is most likely not the case; since already at adolescence most of this sex difference in referral rates has evaporated.

The GIDC diagnose focus on gender non-confirming behaviors. However, the thresholds for gender non-conforming are lower for boys than for girls in society. Parents request professional help once they are sufficiently worried, but they are more likely to be worried if their boy is being feminine, than if it's a daughter that is masculine. We don't view masculinity in girls as that much of a problem, therefore more males get referred. As Asscheman concludes: "a Tommy boy is less of a problem than a Sissy boy for many parents of younger children, reflecting a different referral pattern" (Asscheman, 2009). This makes more boys than girls get the diagnosis.

We can conclude that there is scientific support for the consensus amongst our Norwegian teachers; gender roles are in fact stricter for biologically male children than for their biologically female counterparts. The rigidity of the male gender role causes more males to "overstep" the boundaries for expected gender expression, into what is labeled gender non-conformity. At this point the gender variant males will, in addition, be more severely reprimanded, as hypothesized by participant AH.

3.2.4 Binary versus multi-faceted views on gender

Traditionally, in our culture, as well as in DSM-IV, gender identity, gender role, and gender problems are conceptualized dichotomously (Cohen-Kettenis & Pfäfflin, 2009) with a binary model of gender. However an alternative model is the multi-faceted one. Observing the wide range of variations within genders, many argue that gender is better seen as a continuum (Asscheman, 2009; Benestad, 2009; Benestad, 2010; Bockting, 2008).

Bockting (2008) examines the way transsexuals label themselves as indicative of underlying gender models, and while he finds that the binary model is still present, there are clear tendencies of the multi-faceted model winning ground. However, as stated by Benestad (2010): "Multi gender positivity calls for multi gender-aesthetics", where society creates new standards for what is "normal" or "beautiful" outside the usual gender expressions of the binary model.

Our tradition for a binary gender view is deeply rooted, however. A teacher expressed that if a pupil at her school would show similar gender non-conformity as the children in the

vignettes, they would have “frowned a little, both children and adults alike, and thought that *that was surely* a little different.” (Participant Q, Focus group 4) This teacher describes the dominance of the gender binary model at her school, where straying from the binary is, to a degree, unheard of. She backs up her statements with tradition (as to what is statistically common) and majority consensus (“everybody” would react the same way). Note she does not state that she wants it to be like this, in fact the same teacher goes on to specify that she dearly wished it wouldn’t be like this, but in her mind this is a “reality”; whether one likes it or not, it is a fact of life.

Concerning gender models, teachers seemed careful not to state one model bombastically, especially once they detected differences of opinions on the subject. They talked about this topic especially respectfully and conscientiously. The focus groups would often start out with a binary view on gender being voiced and then reaching resistance, or the other way around, ending on a common understanding leaning towards multi-faceted models. When they questioned the binary model they did so by posing open-ended questions and careful suggestion of more alternatives. The following excerpt demonstrates this process, with one teacher voicing a more traditional binary view on gender, and the responses he receives:

X: I think that I would also say that he *actually* is in fact a boy, though, at one time or another. If I imagine myself having a talk to someone that says he is a girl
[interrupted]

Æ: [interrupts] Yea, but then you might..

X: “Yes, but physically you are a boy.”

Æ: Yes, but he experiences himself as a.. That he is more like a girl, he is entitled to that experience. In a way. [...] And then it becomes kind of.. If we’re going to come and force down like “you are a boy!”. Yes, you are a boy physically, but “I don’t feel like a boy, though”, right?

X: So that.. That becomes a distinction then, is all I’m saying. Or that it.. Then that’s a.. Right, you have to say like “you’re entitled to your experience” and “you feel how you feel”. But.. So that is alright, but you kind of have to.. (Participants X & Æ, Focus group 6)

This debate illustrates in an interesting way the core conflict between opposing models of gender. Note that the notion of a binary gender view feels both logical and intuitively right to some teachers. This is not surprising; a binary gender model has historically been the dominant and most commonly accepted view. While other gender expressions have

undoubtedly been there all along (Feinberg, 1996) they have never fully been accepted as a part of the “normal” variance. However, in the focus groups many teachers rejected the binary as an ultimate “truth” and emphasized the pitfalls; where the binary system does not fit, it will stigmatize anything that falls outside the categories. These individuals become pathologized; diagnosed as abnormal, and find themselves in a minority position inflicted by the majority group. The “natural” category becomes a forced and constructed compartmentalization of the individual (Kessler, 1990); hence some teachers raise their voice in defense.

Teachers in the focus groups seemed to fit in with the descriptions from Bockting (2009); multifaceted views obtaining substantial support. Despite their cautious wording, the predominant attitude seemed one of skepticism towards binary gender models. For instance expressed this way by a teacher: “it’s very, like, 100% boy, 100% girl, there’s no such thing as being able to, like.. You could be.. Kind of a mix, almost.” (Participant B, Focus group 1) What can at first glance be considered an “alternative” or “new” way of looking at gender is not merely an theory within a specific field of science. Rather the ideas appear intuitively in the minds of these teachers and seems plausible to them. The binary model as such, in no way holds absolute reign in the average population of teachers, and it’s fair to assume that this might be the case amongst adult Norwegians in general.

One teacher states that the “problem” is *not* that the child feels like he is a girl. “*That’s not where the problem lies, it lies in the surroundings [...] In that it isn’t understood.*” (Participant H, Focus group 3) Rather than just placing a diagnostic label on gender variance, the multifaceted view requires us to focus our interventions on attitudes in society and ourselves in order to decrease the children’s distress. Benestad (2009) promotes a similar attitude:

Instead of viewing the children as disturbed, they could be seen as children who disturb those around them and that disturbance is reflected back to the children as sanctions of denial and rejection. [...] By decentralizing the therapeutic and educational work [...] and by directing it toward the people who are disturbed by the children, a network of transepositivity can be developed around the child. (P. 215)

Hir highlights the importance of scrutinizing gender views in the people that surround the child, to which teachers are most certainly a part. Both Benestad and participant H sees the value of shifting the focus away from the children and towards prejudice in the surroundings. Interventions should aim towards ensuring positive attitudes, because these attitudes affect the healthy psychological development the gender variant children. Thus; the

gender views of teachers are important, not only because they represent the views of the average adult Norwegian, but also because they directly affects the psychological wellbeing of gender variant children.

3.3 Teachers' perspectives on causes of gender variance

One aspect of the data that stands out in the analysis relates to teachers' talk about the possible "causes" of gender variance. This stands out for two reasons. First, the researcher did not ask teachers what the "cause" might be, yet most groups spent a substantial amount of time discussing possible causes. Second, our analysis of the talk about causes demonstrates the weight that the *idea* of a "cause" has, even in the absence of any solid knowledge of actual causes. If we look back to the end of the 1960's we find explanations from scientists that would vary on the entire range of the nature-nurture spectrum (from biological explanations to dysfunctional family factors). The introduction of GIDC in DSM-III brought with it a new approach. The DSM manual chose a practice of not addressing causes unless there was broad consensus, which there was not in this case (Bryant, 2006). As per now there still is no general agreement on an explanation of gender dysphoria, nor does most research focus on etiology (ibid.).

I begin this paragraph by referring to "causes" in quotation marks. This is because, for analytic reasons, I want to take a critical approach to thinking about causes of gender variance. Some research in this area considers gender variance in terms of pathologizing labels (GID, GIDC), while other research considers gender variance as part of human diversity. Whether one follows the first or the second of these understandings makes a substantial difference to the way one might think about "causes". This is what makes teachers' talk about causes particularly interesting.

Why did teachers view causes as important? Causes seemed primarily to serve two functions. Helping the teachers understand gender variance (in order to decide what to do), and helping the teachers to explain gender variance to parents and peers. As one teacher commented: "No, but if you are [...] supposed to explain [...] I believe in some degree of openness with relation to the peers accepting this, or you don't stand a chance to [...] end it [the bullying] as a teacher [...] It is very hard to explain to the others why he is as he is." (Participant D, Focus group 1) He commented that: "I don't think he [the child] has a lot of

good answers either”. If explanations are indeed needed to create tolerance in the environment surrounding the child, how do we sidestep the fact that we do not know understand it all?

Some teachers used the focus group as an opportunity to explore and think aloud about causes, while others already had pre-established theories about causes going into the focus groups. Explanations varied over the whole continuum from nature to nurture; either they are ‘born that way’ or this behavior is a result of social learning. This mirrors closely a polarization in psychological research. Newman (2002) writes that polarized views about the creation of gender identity essentially revolve around issues of “nature versus nurture”. She sums it up like this:

In biological determinist models, gender identity is seen as founded in prenatal brain development in response to hormonal exposure (Swaab & Fliers, 1985), and largely determines gender role development. In sociocultural models, gender identity is seen as a complex internalization of cultural systems of meaning and subject to variation across cultures and historical periods (Butler, 1990; Mead, 1949). (Newman, 2002, P. 353).

In my study, the teachers being most outspoken about their ideas about causality tended to come from the biological end of the spectrum.

3.3.1 Biologically based; “born with it”?

In an article by Giordano (2008) debating early medical interventions it states that “GID is not purely a social problem: it is a medical condition, whose causes seem to be genetic, hormonal and neuro-developmental” (P. 581) Etiologically most defenders of GIDC do not rely solely on the biological models, however. Most would agree that gender variance is likely caused by a complex interaction of biological, genetic, family, social, and cultural factors (Möller et al., 2009).

In our study, those that viewed gender variance as biologically based often turned to scientifically worded explanations, sometimes backing this up with known examples from research, stories like the case of John/Joan (Diamond, 2004) or from documentaries on radio or television.

I think there’s something in the biology also. Maybe something that occurred in the womb, and we don’t have any official knowledge of this, right. [...] I think it could happen, that they might have had a boy pelvis and then gotten too many girl hormones [...] Also I think that the brain develops very differently than the body, like in the

womb. [...] what I've heard is that [...] if you don't get testosterone, when your head is supposed to become male. And things like that, right? (Participant AC, Focus group 7)

Researchers are still looking into different aspects of biological gender development, looking for factors that might cause or correlate with persistent gender variance. Cohen-Kettenis et al. (2008) claims there is "increasing evidence that GID is not a matter of choice or caused (solely) by environmental factors" (P. 1895). Findings are likely to be complex; biological studies about gender have revealed cascades of genetic and hormonal events in the sexual differentiation process (Benestad, 2010). With regards to the participants focus on hormones, this has long been suspected as an underlying factor behind gender variance. Asscheman (2009) explains that some studies have examined the role of pubertal hormones in brain development, but that no clear conclusions can be drawn. While the findings connect levels of prenatal hormone exposure to gendered child play behavior, this does not seem to be the most important factor in developing gender identity.

When arguing biological causes, some teachers referred to anecdotal evidence regarding trans people they know, who had the same feeling of gender identity since they were children. One teacher explained that if the child is "trapped in [...] the wrong gender. Or the wrong body [...]" "then that is something "he'll have for the rest of his life" (Participant Æ, Focus group 6). A biological cause, thus, seemed to coexist with beliefs that gender variance is *stable*; the child will remain gender variant. It also seemed to accompany the beliefs that gender identity is something of the mind. In these teachers' views, the child's mind should not be target for intervention. When teachers believe that children are "born that way", changing the mind is seen as wrong because it "tampers with nature" (ibid.).

3.3.2 Social learning?

"I'm sure that a boy who is effeminate knows very well what boys *do* and what is masculine. But [they] have then "chosen" something different." (Participant G, Focus group 2).

Fewer participants seemed to think gender variance could be caused by social learning, and could hence be "unlearned". More often this was worded as an important competing hypothesis; something to "keep in mind as an option", with a potential of things "sorting themselves out". One teacher (Participant AH, Focus group 8) described a child she

knows. The child was gender variant at young age, but “blossomed” once puberty hit and has since been gender conforming. The teacher concluded her story with a cautiously worded warning about this being “something that might pass” and that “it could go either way” (ibid.)

Research suggests that participant AH’s experience is quite common. Environment does have impact on gender identity. This is obvious from reports of desistance rates in gender variant children. In fact, as previously mentioned, most gender variant children will not grow up with persistent gender dysphoria (Drummond et al., 2008). There is even the somewhat rare report of a male born child raised as a female, who reported her identity to be that of a woman when interviewed as an adult, hence giving the opposite outcome than the well-known John/Joan case (Bradley et al, 1998 as cited in Diamond, 2004).

While these examples demonstrate that gender variance is not always biological or fixed, it does not reveal *how* the environment might influence gender identity. Zucker (2008a) believes that gender variance might originate from a series of non-biological causes. I.e.: psychopathology in the parents, separation anxiety (Zucker, 2004), insecure attachment between child and mother, insufficient father-son time or parental reactions to early cross-gender behavior (Zucker, 2008a). When teachers explored social learning as potential cause of gender variance, they focus on trends in society, learning via the media or being raised by same sex parents (Participant A, Focus group 1). They stated that if sexual identity or orientation were to be “chosen” because it is “trendy”, child could be discouraged (Participant R, Focus group 5; Participant Y, Focus group 6).

3.3.3 “Causes” in a multi-faceted gender model?

Whether one sees gender variance as biologically based or socially learned it implies the need of aligning the subjective gender with the body. A constructionist take on this would be to say that society’s view on gender is what needs changing. The rigid gender categories are in need of interventions. When exploring causes, one debate that I found particularly interesting questioned whether one can really be born in the “wrong” body, or whether this just show that two categories of gender is not enough (as is the view in multifaceted theory of gender). While talking about causes, one group had the following exchange of thoughts:

AD: I think that this is, uhm, as you say a person born in, in the wrong body. Uhm. So of course that’s a big.. A serious problem as well. [...]

AF: I just thought a little bit about what you said now, that one is born in the wrong body, because I have thought about that. [...] What *is* that? And then I thought: “is it possible?” To be born in the wrong body?

AD: No. No, and that is very, very interesting in regards.. Well, in regards to plastic surgery; breast surgery, that is. One hears “I did not feel like a woman before I got silicone implants” And that’s very *sad*. [...] But as you say, is it something with the mind? Or society, that..

AC: If anything should be changed, is it the body or the mind, kind of? Uhm.. I haven’t found any [answers]. (Participants AC, AD & AF, Focus group 7)

When teachers seemed to truly question if the label “disorder” is at its place here they seem to approach the theme of causes entirely differently. The excerpt seems to imply that the body is “right” while society is wrong for making us believe that we have to fit into such narrow categories. This falls along the constructionist view, seeing gender variety not as a disorder with a cause, but rather as an expression of natural gender diversity.

The concept of being born in the “wrong” body is in a way contributing to pathologize gender diversity (Roen, 2001). As demonstrated in the previous excerpt, and throughout this chapter, teachers’ thoughts around “causes” and “cures” seems to reflect a mind/body debate, as well as underlying gender models. The binary model of gender demands the answer as to *why* the individual child does not fit the categories, whereas within multifaceted model of gender, talking about causes seems to be strange and obsolete.

When addressing normality within a spectrum we rarely look as vigorously for causes as when something needs fixing. That implies we need it to change. Whether gender variance is something people are born with, or something they have learned, is it something that needs to be changed? If we accept the statement about being born in the wrong body we are also anchoring traditional beliefs about how a female or male body should look.

A transgendered friend of Benestad in hir article (2010) is quoted to have said “I never say that I was born in a wrong body, because if I had been born in another body I would not have been me”.

3.4 Teachers’ views on the importance of the child’s age

Age was often brought up as a factor in the focus groups, for instance when talking about potential outcomes, weighing different courses, considering which psychologist to choose or questioning the validity of the vignettes. Central to this was the guideline of what constitutes a “normal” development and the powerful idea of “normal childhood”. The

teachers drew heavily on their experiences with children of different age groups; what kind of challenges these children are likely to encounter and what they are mature enough to handle.

The topic of age presented itself in all 8 focus groups. It is somewhat surprising that age was so prominent in the debate; the age of the vignette children was not a variable factor, nor was talking about age prompted by any question. Age appeared, however, from the very first focus group to be an ever-present factor with major influence almost every response made. It was articulated on several occasions that had the age been different, their answers might also have been (Participant A, B & D, Focus group 1; Participant E & G, Focus group 2; Participant H & K, Focus group 3, Participant S, Focus group 5; Participant Ø & AA, Focus group 6; Participant AC & AD, Focus group 7, Participant AH, Focus group 8). “It has to do with how mature the child is and how much of an overview they have over their situation, and influence on their situation. So, the younger and smaller the child.. In a way.” (Participant AC, Focus group 7).

From the teachers’ viewpoints, low age in the gender variant child made the situation more difficult to deal with. Reminding each other of the young age seemed to heighten their sense of responsibility. When brought to the table the factor of age seemed to be a trump card for statements of caution and taking it slow. Worries of doing something wrong, potentially adding to the distress, seemed to lurk in the background. This is a well granted fear, as many transgendered adults recall childhood and adolescence as traumatic (Benestad, 2010).

The teachers’ fears have parallels to the experiences of psychologists working with gender variant children. For both teacher and psychologist alike, working with gender variant children seems to bring a variety of potential pitfalls and considerable challenges. The uncertainty of the outcome, combined with ideas about children’s fragility, leaves many professionals with a feeling described as working “on the edge”; a feeling of the process being “risky and anxiety provoking” (Di Ceglie, 2008, P. 406).

3.4.1 “It’s too early”

G: Well it’s very young, he is just 11. [interrupted]

E: [interrupts] Yes, I think it’s far too early.

F: 11 years is very early, so that I think that I would think that .. uhm.. Even thinking about anything .. [...] Like changing gender would just be wrong [interrupted]

G: [interrupts] For an 11 year old yes..

E: [...] And the moment you change names, it becomes like kind of a new identity. So that I. I would bring that up.. [interrupted]

G: [interrupts] 11 years old is.. They are just kids, yeah. (Participant E, F, G, Focus group 2)

Many of the statements the teachers made were worded: “it’s too early”. This was often worded without a follow up explanation or elaboration, and almost more of an emotional statement than a formed argument, often expressing distress, helplessness or not knowing what to do. Nowhere was the idea of ideal normality more apparent than here, the teachers expressed distress about the child being unable to live the idea of “normal growing up”. At this point, teachers seemed presume they have similar expectations as to what “normal” childhood is. They also base this on ideas about what decisions a child is mature enough to make at a certain age or what amount of negative reactions from the surroundings they would be strong enough to cope with. The child is simply too young to decide or too young to deal with the ramifications of it. In result the statement “it’s too early” often held the function of a break, introduced when statements about supporting the child’s decision or aiding or supporting gender non-conforming behavior became too prominent in the group or when they were expressed too liberally.

I’m thinking that you get influenced in so many, like things you do and say and the way you act as a young person, it’s all memories.. Childhood is such a powerful time, you carry with you those memories for the rest of your life, and it shapes your identity, but if you get the space to evolve without it being.. [...] Then you get the option to choose as things progress. Like, the more you narrow it down, the more you go out publically, more and more you narrow down the option and the choices for who you are. (Participant A, Focus group 1)

3.4.2 Different phases of life

AD: And.. And, and very sad that they are so young, because they don’t have any references to.. Uhm.. Anything. Anything much in life. It’s hard, everything gets hard. It isn’t.. And those.. And children, they live in the *present*. They aren’t [going to say] “nah, I’ll deal with this when I’m 18 and can decide for myself!” [laughs] One wants to act now, right?

AF: Yea and you don’t have the kind of role models..

AC: Cause that's the difference between being 20 and 11, right? (Participants AC, AF, AD, Focus group 7)"

Age was also brought up in statements about life phases. Rather than stating it's too early some were preoccupied with it being at a particular life phase. Usually this would address one of 2 arguments: 1) the child is in a phase of life where confusion about identity is normal, making this a non-event or 2) the child is in a phase in life that is the wrong one for transitioning in any extent. Openly living in a female gender role ("coming out") at this point would be the wrong thing to do. Both statements are as such encouraging either a halt or a break in the child's progression towards transitioning. Interestingly enough some teachers made comments that indicate that they also have ideas about "correct" progression of events in homosexuals or transgendered, there is a "right phase" and a "wrong phase" for coming out.

Argument 1 implies that it is a normal phase that children will grow out of and is not to be meddled with. For example when a teacher says that "but *everyone* is in an identity crisis" (Participant AA, Focus group 6) Argument 2 implies that this is not "normal". But although coming out might be right later, it should not happen in this particular phase. In later stages it may be easier to "be yourself". This is expressed in the following excerpt:

I think that both in elementary and secondary school it's kind of very vulnerable times when you are different on those kinds of things.. And that to be [different] like that, that's very, very difficult. And I think many also, that have something special about them, find more security in high school, where there is a lot more acceptance for who you are and that like you can be yourself to a much bigger degree. Cause if you look at a secondary school, everyone dresses the same as whoever is the leader of the pack, while in high school you might get praise for dressing a little differently, and [having] your own style (Participant D, focus group 1)

This teacher thinks in terms of different phases, which makes for different challenges for the children. He describes a change occurring in the transition to secondary school. Wallien and Cohen-Kettenis (2008) saw evidence for similar "phases" in their follow ups with gender dysphoric children. Desisting participants with gender dysphoria frequently reported that the change had happened with the entrance into secondary school. If this can be replicated in more systematic follow-ups, it would indicate that there are indeed certain phases where desistence is more likely to occur. Similarly, Zucker (2008a) suggests toddler and preschool years as sensitive periods for the formation and development of gender identity.

The age of 11 is described by teachers as a very vulnerable phase. At this phase of life peer acceptance and fitting in is very important to the children. One teacher goes as far as saying that self-image at this age is dictated *fully* by what other people say (Participant AD, Focus group 7). According to this teacher their sense of identity is all about how others perceive them or they say to them, and that they don't have the capacity to understand that you are "totally ok" regardless of what others say (ibid.).

Many teachers focused on the phase of puberty in particular, and addressed the challenges that would be approaching. Puberty was described by them as an age of many confusing changes and feelings for children, a difficult age to any child. They encouraged caution and not to make any major life changes because of this or pointed out how this phase might be particularly hard and painful for the children in question. That they will have "bigger difficulties" and might need a little extra follow up (Participant G, focus group 2) The difficulty of this phase has also been many times reestablished in self-reports from transgendered individuals, sometimes describing it as "unbearable" (Wren, 2004 as cited in Roen et al., 2011). It can be crushing, being forced to live through the development from a more neutral child's body into a sexually mature adult with full gender characteristics that feel "wrong".

Clinicians around the world debate the pros and cons of the use of puberty delaying drugs; arguments for the use includes reduction of distress and better prognosis for SRS (being able to "pass" as the reassigned gender after surgery), arguments against involve unknown risks, potential regret and possibility of influencing outcome by this treatment. Harry Benjamin International Standards of Care have stated that children need have *some* experience in their biological gender, and the Royal College of Psychiatrists recommend that children, if possible, get experiences in the post-pubertal state of their biological sex (Giordano, 2008). Similar notions were expressed by teachers, for instance one teacher that said: "Helping them to transition? But they haven't even fully developed their own biological gender yet! Isn't that kind of.." (Participant B, Focus group 1)

It's important to note that while the use of puberty suppressing drugs is a prominent international debate within the field of psychological research on gender (Reed, Cohen-Kettenis, Reed & Spack, 2008), the teachers in our focus groups seemed either not to know about or else not consider the option of this intervention. As medical interventions they focused mainly on surgery. Only one teacher mentioned hormone treatment briefly, that the children could take "one of those shots, and then they enter puberty at 16 instead" (Participant

AC, Focus group 7). Because of this, the possibility of *not* having to undergo normal puberty was not included in the scenarios focus groups had about outcomes or treatment. Even amongst the most liberal of the teachers there seemed to be a reigning consent that the children would have to live through puberty without being able to do any medical changes about their gender. The children would have to wait until the age of 18 before potentially being considered for gender reassignment surgery and cross-gender hormone treatment. For instance it was stated that “surgeries and things like that [...] won’t happen anyway, while the person is in puberty. You need to be an adult and of age and.. To have the option to do something physically about it, I think, I mean I know.” (Participant AH, Focus group 6) Statements like these were worded in a matter-of-factly manner, and not really questioned by the groups in any way. As the excerpt shows the teacher even corrects the “I think” to “I know”, as such it seemed to be a part of “common knowledge”. This indicates that hormonal interventions are not as visible as SRS in current media coverage. It seems a criteria that for teachers to be positive towards a potential early transition, they need to know about the options of administrating puberty suppressing drugs.

3.4.3 “Could it just be a phase?”

“Because like, they’re just 11 years old, so things could change so many times before they are adults” (Participant H, Focus group 3) Associated with the idea of “normal” childhood is the notion that children will pass through phases that, although significant then and there, will not last or change anything overall in the child’s life and that should not invoke any changes in the surroundings. Teachers expressed worry; what if the child grows out the feeling of dysphoria, but becomes trapped under a label that limits their choices and that might not feel right anymore. A few of them also verbalized direct questions about the chances of this being the case.

Psychological researchers have examined rates of persistence in GIDC. Studies of children with reported gender dysphoria have found, in some cases, to have as many as 88% of the children in question (girls in this case) report *no* distress about their gender identity when they are asked at a later follow up (Drummond et al., 2008). Only by the onset of puberty might it be more likely for professionals to make a reliable prognosis (Reed et al. 2008). In other words, gender dysphoria has significantly less prediction value in childhood than in adolescence. Similarly, puberty were viewed by some teachers (Participant Z & AA,

Focus group 6; Participant AH, Focus group 8) as a potential catalyst for “knowing more certainly”, possibly terminating gender dysphoria if it had been a phase.

The prospect of gender variance being just a phase was something that the teachers felt they should be aware of, but not necessarily mention to the child. In a few groups they discussed worries and dangers with verbalizing this to the child (Focus group 3; Focus group 5). The teachers agreed on being cautious about presenting these kinds of ideas to gender variant children. Major concerns were that saying this would alienate the child, potentially add to the distress, scaring it from being open, making it feel like it’s not taken seriously and betraying the child’s trust. One teacher described it as being “the opposite of accepting” and highlighted the importance and difficulty of phrasing things in a good way (Participant H, Focus group 3). For these teachers, it seemed that accepting the *permanence* of the gender variance, and not challenging it, was a primary criterion for being supportive.

3.4.4 Validity of the child’s opinions

In a majority of the focus groups, a few teachers questioned the validity of the child’s statements on account of young/ age (Participant B & D, Focus group 1; Participant G & E, Focus group 2; Participant J, Focus group 3; Participant P, Focus group 4; Participant X & AA, Focus group 6; Participant AG & AH, Focus group 8). These teachers did not necessarily state or conclude that the child’s opinion had no validity; their questions had the function of inviting to debate. They questioned what children should be allowed to decide at this age. What can they know for certain about who they are or will be? Can the children successfully predict long term consequences? Will they be able anticipate the reactions they will get from the surroundings? Can they anticipate changes in their own perception? What areas of their lives should these children be allowed to influence?

Some teachers felt the low age means the children’s beliefs don’t hold as much validity; stating that at age 11 they are really too young to know what they want. Arguments include that they cannot see consequences fully, or that they wouldn’t know these things because they are not even fully developed in their born gender yet, or that the maturity level isn’t enough to decide in that large decisions. Teachers arguing this position seemed to agree that this is a matter professionals or parents, to decide for the child. They argue that there are reasons that such “serious decisions” should not be taken by children, considering both children’s “physiological as well as psychological development” (Participants AH, Focus groups 8).

Other teachers expressed the opposite opinion, either disagreeing that 11 is too young, or arguing that regardless of young age the children's feelings are to be taken seriously. At age 11 children have a good deal of insight in themselves (Participant AD, Focus group 7). Looking back at own experiences another teacher describes that they "knew quite a lot when we were 11 as well, what we liked and didn't like, what we wanted or didn't want, at least" (Participant Z, Focus group 6). She goes on to argue that children need that their experiences be taken seriously. We cannot presume to know better what someone feels than the person feeling it. "If a 6 year old says "I am in love", and you say "no, you are too young to be", but there are those that *really* experience those feelings for another person then, so.. Those feelings are there!" (ibid.). It is also pointed out that openly questioning the validity of the child's feelings is often, in addition, quite counterproductive. The teacher comments that "we can imagine for ourselves, if someone forces us to be someone other than who we are" (ibid.).

Some teachers commented separately that they were surprised to see such determinacy operate at such a low age. These teachers read it as evidence that the child was "born with it", supporting the view of the child's perceived gender identity as "true" and stable. Teachers also viewed the high degree of certainty and openness as a sign of it being unaffected by media and surroundings. They commented that there was less likelihood of this being influenced by trends, since the child unlikely to have been exposed to a vast amount of media pressure yet (Participants N & P, Focus group 4). In this case the low age was not a factor that questioned the validity of the child's beliefs, but rather the opposite; an indication that this is deeply rooted in the child. According to Roen (2011) similar thinking is most likely present in the medical community. This is however not unproblematic, because it does contribute to creating an unhealthy hierarchy amongst young transgendered people, where children that seek transitioning early are seen as "more plausible candidates" then those that request it later in life. When the gender dysphoria is so clearly formulated in the mind of the child from such an early time, others are likely to view it as more substantial. Positive as this might seem however, as demonstrated by Roen's article, this might be on expense of children less direct or more inconsistent about their experiences, making teachers more likely to take these children's feelings at face value, advocating one distinct narrative as the "correct" one.

In conclusion; teachers are cautious with assuming stability of gender variance in children of low age. If possible they wish to stall the processes of "coming out" publically or committing long-term to a change in gender, as well as medical interventions. They seemed unaware of puberty suppressing drugs as a possible treatment option.

3.5 Teachers' introspection on their emotional responses.

In this section I will take a closer look at the teachers' emotional experiences. The teachers in our focus groups shared thoughts about their own experiences and role in this situation with each other. This section will analyze the teacher's emotions towards the vignettes, as well as feelings of perceived competency.

3.5.1 Teachers' emotions

“Q: You get an overwhelming urge to nurture, you feel empathy. You.. Like, you want to help. You want to.. It doesn't matter *why* the kids are hurting. [...] Even if they hurt their knees as tiny first graders [laughs] or if they.. [interrupted]

P: [interrupts] That is why we do this! [laughs]

N: Yes, that is why we work. That's why we have this job”

(Participants N, P & Q, Focus group 4)

In the classroom, teachers' emotions influence their attention, memory, coping skills and several other aspects of teaching (Sutton & Wheatley, 2003). Even more importantly it affects the pupils they teach, and the classroom as such can be a powerful social context. Pupils pick up on, and respond to emotional expression as well as physiological changes as they observe their teachers in the classroom. One teacher said: “There are so many ways to express.. You can express accept in so many ways, through a look, a pat on the back, and constantly kind of.. giving the thumbs up.” (Participant AD, Focus group 7) This excerpt comments nicely on the emotional exchange that can take place between teacher and pupil. Teachers convey a sense of general approval or disapproval to the student (Birch & Ladd, 1996; Wentzel, 1996 as cited in Harter, 1996) as well as their degree of caring (Wong & Dornbusch, 2000; Reyna & Weiner, 2001 as cited in Sutton & Wheatley, 2003). Students' belief that their teacher likes them or cares about them has been found to result in less delinquency, more motivation, more helpfulness and more obedience to classroom rules and norms (Wong & Dornbusch, 2000 in Sutton & Wheatley, 2003). Teacher support might also serve to compensate for low parental support and can have a profound impact on self-esteem in children (Harter 1996). As shown here there are numerous important ways in which teachers' emotions will affect gender variant children, both directly and via the influence teachers will have on their classmates.

In the focus groups we wanted to encourage talking about emotional aspects of relating to the vignettes. Acknowledging that spontaneous talk about emotions is often rarer than if asked directly, it was decided to include a direct question about emotions in the structured questions for the focus groups. In an interview study of middle school teachers in the USA, mentioning emotions, like love, only occurred in 10% of teachers, whilst 70% of the teachers named it as a relevant emotion when given a list (Sutton, 2000 as cited in Sutton & Wheatley, 2003). Similar to this, the replies to our open question about emotions often came after a long silence where teachers were thinking hard and digging deep. Many teachers said that this question was particularly hard to reply to. It should be mentioned that explicit talking about emotions was sparse, and that teachers answered more commonly in terms of their appraisal of the situation, about the child's needs or other thoughts they were preoccupied with.

Those that did name emotions often mentioned negative ones in response to reading about a child's distress. Emotionally they reported feeling sad or sorry for the child (Participant G, Focus group 2; Participant X and Z, Focus group 6, Participant AD, Focus group 7). Sadness is often interpreted as an emotion that follows what is appraised as "irrevocable loss" (Sutton & Wheatley, 2003). If this applies here, it might be that they perceive the child as permanently losing their chance for a "normal", "happy" childhood. Underlying here there might be a belief that being gender variant makes a happy well-adjusted childhood impossible. In focus group 7, they felt sad about the child's loneliness and isolation; lacking any role models to identify with at all. One teacher expressed helplessness, because she didn't know what to do to make it better (Participant AH, Focus group 8). Another teacher (focus group 7) spoke empathically from the child's perspective; "I don't resemble *anyone*! There is no one that is like me..". Some reported feeling angry on behalf of the children, because no one had prevented harm or helped them (Participant G, Focus group 2), or they were angry with the surroundings having caused a lot of the distress (Focus group 2). Here the loss of a "normal" childhood is possibly perceived as having been "taken" from the children by the people in the child's surroundings.

In focus group 6 one teacher reported feeling guilty over not having done anything sooner and letting it progress this far. She elaborated, saying that she that if she had done something it surely mustn't have worked and she'd feel guilt and responsibility for not having been there (Participant Y, Focus group 6). Hargreaves and Tucker (1991, as cited in Sutton & Wheatley, 2003) state that, in the emotional life of elementary school teachers, guilt is a key

feature. Another teacher said: “You get like an “aaah”, you’re hit in the gut, because it’s really quite serious. It’s not something one can put a Band-Aid on. [...] And you feel the weight of the enormous responsibility you actually have, at least I do.” (Participant Q, Focus group 4) While some teachers externalize, feeling anger towards an undefined “others” who made life hard for these children, other are shown to internalize and direct the same responsibilities and anger at themselves in the form of guilt.

Other commonly named affective responses were “nurturing” feelings; feelings of compassion, empathy or a desire to help and protect. In these feelings we see a clear core belief that the children (possibly about all children) are fragile and helpless, and have means of protecting themselves. It further conveys the appraisal that these children are in great need of help and that it is the duty of adults to help them. “First and foremost as a mother [...] to an 11 year old.. [...] I would have thought this is my child, this is my *baby* [...] I *have* to do something!” (Participant A, Focus group 1)

3.5.2 Teachers’ feelings of competence

In addition to talking about feelings towards gender variant children, teachers’ replies also offered understanding of how they felt about being in their position. At a core level these statements usually described feelings of perceived competence/incompetence in dealing successfully with gender variant children and we will deal with them separately.

There is surprisingly little research about the emotional aspects of teachers’ lives, as pointed out by Sutton and Wheatley (2003). And there are even fewer studies on the significance of feelings of competence in teachers. Out of the sparse research on teacher’s feelings of efficacy, most is about their perceived efficacy as *teachers*; in passing on knowledge to their pupils. However in our case the efficacy concerns their ability to maintain psychological wellbeing in their pupils, and resolving complex social situations within and between the pupils they are in charge of.

Feelings of competence or incompetence guides a teacher’s *behavior* in their real life encounters with gender variance. A teacher who feels high in competence will address gender variance differently than one that feels highly incompetent. In addition, these feelings of competence or incompetence influence how teachers feel about being in their shoes and having to deal with a gender variant child.

The consequent behaviors can be important in their own right, generating concrete and distinct consequences (I.e. initiating a class meeting, addressing bullying or bringing in

professionals to help). It can also be a matter of less tangible behaviors that, while appearing insignificant, are crucial to emotional and social exchange (i.e. a touch or a smile, initiating informal conversations or the absence of these). Small nuances of involvement or avoidance are likely to affect a gender variant child's feelings of being liked, supported and accepted. The feelings of competence or incompetence will convey a sense of optimism or pessimism to the pupils, generating feelings of hopelessness or hopefulness in them. All of these elements can affect the children's emotional wellbeing.

In the following section we will focus on aspects of feeling competent or incompetent that influences the emotional wellbeing of the gender variant child. Few focus groups fit neatly into each category, indicating that the level of perceived efficacy is highly individual. Also, within each teacher are conflicting feelings of both high and low competence that exists alongside each other.

Influences on the gender variant child's emotional wellbeing

One teacher commented that because they have such a "varied group of pupils already" a gender variant child posed no particular problem, but is a "typical part of the teachers job" (Participant N, Focus group 4). Gender variance, she stated, is simply "another way to be different". The teacher further characterized the work of changing peer attitudes as "simply a methodological and tactical challenge, but we would figure that out. No problem!".

Reports of a high feeling of competence were often characterized by teachers viewing gender variance as a part of general diversity. When gender variant children fall inside the spectrum of "normality", the teachers do not view themselves as "novices". This allows teachers to build on previous experiences with children who needed help being integrated in the class or that were unhappy or ill. The teachers draw from these experiences, confidently choosing similar courses of action and concluding that this is something they can deal with.

Viewing gender variance as a part of diversity is likely to have a positive effect on the gender variant child's emotional wellbeing, generating what Benestad would describe as "transe-positivity" (Raj, 2000 as cited in Benestad 2010). The teacher is less anxious and likely to participate in usual interaction with the child, seeing it like "any other pupil". It is less likely to provoke common feelings of shame (Benestad, 2010) in the gender variant child, and might help normalize gender variance both in the eyes of the peers, and in the gender variant child itself.

Benestad (2010) states that successful assistance of gender variant children, rests on a premise of ensuring gender belonging. Hir claims that a criterion for obtaining this is that “the gender perceived is given a positive value, both by the individual and others” (P. 226). Hir mentions teachers as one of many primary groups that affirm a person’s gender expression. While teachers with feelings of high competence might not necessarily put a *positive* value on the child’s perceived gender, it does seem that they are closer to this goal than teachers with lower feelings of competence.

Teachers reporting high feelings of competence also seemed to consider themselves as an important influence for their pupils (Participant C, Focus group 1; Participant L & J, Focus group 3; Participant N & P, Focus group 4; Participant AD, Focus group 7). One teacher stated that it is “incredible how much power we have as adults”, and how accepting children can become if you as an adult accommodate things, talk with them openly in a dialog (Participant N, Focus group 4). It is likely that this belief will cause teachers to work actively towards being a good role model for tolerant attitudes.

As a contrast to the thinking of “we can do anything we set our minds to” is the mindset of limited or part-competence, where, although one might have no competence on a specific area one might feel well skilled to deal with other parts of the problem. Many teachers expressed this kind of sober thinking; although they felt inadequately trained to “deal with” gender dysphoria and did not equal this with “usual diversity”, they did feel that parts of the scenario were well-known and successfully dealt with in their past. Issues that these teachers felt well skilled to cope with were integrating the child into the class, dealing with unhappy children that do not want to talk, cooperating with parents and ensuring the child is safe from bullying. Some also felt that self-harm and depressions are things they can help the child overcome. Most, however, drew the line at gender dysphoria, being afraid to cause more harm than good if they were to try resolving anything there. It is interesting that some felt that they might be competent to deal with depressions and self-harm, illustrating further that gender dysphoria is not only set apart from “normality”, but also to an extent from more common psychological disorders.

Placing gender dysphoria as an off-limits topic for others to deal with, and instead focus on the more common aspects of the vignettes, shows again how “different” and “alien” this issue might seem to some. As the only issue that falls outside the range of their perceived competence, it is likely to presume that they put it in a category of “abnormality” that is left for professionals to deal with. Based on this I think it is likely to assume they are not seeing

gender dysphoria as simply “natural diversity”, but labeling it clearly as a disorder that they have no more skills to deal with than a heart condition. One can imagine that on the receiving end, as a gender variant child, this might make it feel that it has to hide the gender variance in order to not alienate or “scare” the teacher. It is also likely to convey a sense of severity and somberness that might scare the child and add to distress.

In teachers who reported low self-perceived competence they felt they lacked both knowledge and influence on their pupils. These teachers felt like they do not know enough to do anything, and if they did do anything it would be likely to either not have any effect. This caused one teacher to ask the following question: “To what extent is this our business? How much can we as teachers be expected to do anything for this kind of pupil [...]?” (Participant D, Focus group 1) Others seemed overwhelmed by the possibility of maybe making things worse (Participant G, Focus group 2; Participant AA, Focus group 6). Their statements generally showed a relatively high emotional content; expressing confusion, pessimism, frustration and helplessness. “This *thing* [...] I don’t know anything about this! I don’t know. I can’t do this.” (Participant G, Focus group 2). It is worrying to consider what effects it might have if the children, their parents or peers pick up on and absorb this general feeling of hopelessness and helplessness.

Considering the feelings of being overwhelmed and confused, it is not surprising that some of these teachers questioned the “realness” of gender variance (Participant X & Participant Y, Focus group 6; Participant D, Focus group 1). One teacher asked “Is this a *natural* behavior it is showing? [...] or is [it] an act?” (Participant Y, Focus group 6) Another teacher exclaimed that “even *scientists* are arguing about whether it exists” (Participant D, Focus group 1). These teachers were unsure of what to make of the child’s perceived gender, and were skeptical to the idea of perceived gender ever being “truer” than the physical gender. In a way it questions whether transgender identity actually exists.

Vanderburgh (2009) describes several instances where this notion has been expressed by psychologists, and argues that this belief causes emotional distress for many transgendered people. According to Vanderburgh this sends the message that “therapy is something to be avoided” (P. 140). Similarly it is likely that gender variant children, who pick up on similar beliefs in their teachers, might conclude that being openly about their gender variance is to be avoided, since no one will ever believe their own experience of themselves. Emotionally, a fundamental questioning of the “realness” of their experienced identity attitude is likely to

add to the confusion and frustration that gender variant persons already feel (Lev, 2005), increasing potential feelings of shame and of being “abnormal”.

Despite these potential negative implications, it is important to note that teachers, who were questioning the validity of gender variance, were not in any way showing a lack of empathy towards the gender variant children. Rather their questions might reflect the fact that gender variance still needs to become more “visible”. When rarely spoken about, it becomes hard to relate to, and remains mysterious and “alien”. Continuing focus on gender variance and spreading knowledge is vital to help teachers in promoting productive views towards gender variance.

Influences on the cooperation with therapists

Bringing in other professionals was a common theme in all groups of high and low feelings of competence. However, the teachers that reported a high feeling of competence tended towards considering themselves as being part of a team of professionals (therapists included) that were to work with this, as opposed to “handing over” the problem to more “proper” departments. Teachers with high feelings of competence did in no way see themselves as passive bystanders to the process of helping this child’s development. As expressed by Participant O: “I don’t feel that [...] the moment a psychologist [...] has been involved you have *handed over the case*” (Focus group 4). Participant AC (Focus group 7) further specified it as part of her responsibility as a teacher to “make sure the child got the help it needed in time”.

The teachers who considered themselves more competent viewed a positive outcome as a result of a team effort. They explicitly stated the value of team-meetings, and of seeking help and support from colleagues and other professions (Participant A & D, Focus group 1;; Participant G & E, Focus group 2; Participant J, L & Q, Focus group 4; Participant R, Focus group 5; Participant AC, Focus group 7). They saw themselves as important participants in ensuring the healthy development and emotional wellbeing of the child, and many expressed a strong in their groups ability to “deal with anything” (Participant Q, Focus group 4; Participant R, Focus group 5).

Encountering a group of teachers with this attitude this, as a psychologist, cannot be seen as anything but an immense resource. As influences on class environment, and as role models that help the child towards self-acceptance, getting the support given by these teachers would be an important tool. This would however not appear automatically. These teachers,

would not have a passive and uncritical attitude towards the interventions (Participant Q, Focus group 4). The interventions would have to seem reasonable and plausible. Hence, if the psychologist wants their support, he/she must convince them of the validity of the therapeutic methods in question.

Focus group 4 articulated their thoughts about what it would require for them to work well together with a psychologist. They put emphasis on wanting the psychologist to involve them as part of the process, listening to their experiences. The flow of information should go both ways. Focus group 4 stressed the importance of the psychologist giving them the information they needed to be of help to the child, urging the psychologist to not “close the blinds” on them (Participant Q, Focus group 4) They expressed hope that the psychologist would recognize the fact that they, as teachers, could be of “invaluable help”, crucial for the therapy to succeed (Participant N, Focus group 4).

It is worth noting here that their faith in their own abilities, seemed to rest on the good intentions behind the actions, rather the actions necessarily being the “correct” ones (Participant F& G; Focus group 2; Participant AD, Focus group 7) This might be an advantage in when dealing with gender variant children, since it often involves having to accept a lot of uncertainties. In the group of teachers expressing low feelings of competence, on the other hand, this was not the case. Understanding *fully* the causes and nature of this, and having clear cut answers ready, seemed to be imperative for some of these teachers. Indeed lacking this knowledge, was part of why they felt incompetent. Participant D (Focus group 1) expressed a particularly high degree of frustration with this. He explained how impossible it was for teachers to know what to do, when they did not know whether the children would grow up to be heterosexual, homosexual, transsexual or something else. He concluded that they needed help from other professions “faster than greased lightning” (Participant D, Focus group 1).

Unfortunately, knowing the outcome for young gender variant children is in all likelihood impossible, (Vanderburgh, 2009) and in most cases one will have to wait and see what the child grows up wanting to identify as. This might be disappointing and discouraging to teachers seeking “hard” knowledge. It becomes the psychologists challenge to inspire to faith and patience with the therapeutic process, even though the psychologist cannot offer the answers they seek.

In the teachers that reported low feelings of competence, their influence was experienced as very restricted to the confines of the classroom and the hours of the school day

(Participant A, Focus group 1; Participant E, Focus group 2; Participant Ø, Focus group 6). Outside of this the child would mostly be left to its own devices to be mercilessly picked on outside school. While this might be close to the case, it is easy to see that this belief can make teachers give up and be passive towards the many aspects they could influence in a positive way.

In addition to feeling generally powerless, they felt so even more in regards to working with psychologists (Participant D, Focus group 1; Participant F, Focus group 2) . Teachers in this group expressed limited trust towards the profession, and the notion of cooperating with psychologists did not make them optimistic. Some questioned whether help would be available and appear in time (Participant AC, Focus group 7). Others reported that cooperation with other professions left teachers powerless towards the “higher authority”, and that the teachers’ opinions would matter very little (Participant AD, Focus group 7; Participant N, Focus group 4).

In meeting these teachers it becomes important that psychologists are aware that this skepticism might exist so that they hopefully prove them wrong. Distributing knowledge about gender variance that frames it in a less scaring, but realistic light might be part of it. Talking and thinking about gender issues and inviting these teachers to share their perspectives might be another. Perhaps most constructive is to build these up these teachers feelings of competence; making see the already existing competence and importance that comes with their unique position and their experience with these children.

3.6 Teachers debating therapeutic approaches

“Is it something about the mind that should have been changed, in a way? It’s very.. Is it the body or is it the mind, to put it bluntly.” (Participant AC, Focus group 7)

Should one attempt to change the gender dysphoria by working on the mind of these children, or should their body be altered to fit their perception? This question is not only on the minds of teachers trying to make heads or tails about good intervention for youngsters with gender dysphoria. Indeed this question has been debated since the 1960’s where the majority of medical professionals in the USA felt it was wiser to change the mind instead of the body, while others, like Harry Benjamin, held the opposite opinion (Bryant, 2006). Even today current articles in the field of research on GIDC demonstrate the same polarization, with differing views both with regards to etiology as well as best practice.

Although there are a myriad of different takes on this, these differences in practice are interestingly enough not generally focused on, (ibid.). Bryant refers to an interview with someone he describes as a “leading GIDC defender”, who says that “there are no systematic, comparative, treatment studies . . . nobody ever publishes data about what happens in therapy” (interview with author, October 22, 2003 in Bryant, 2006). Likewise DSM-IV offers no guidelines about what treatment one should give a child with GIDC (applies for most diagnosis). Needless to say this poses a challenge for clinicians. With a lack of consensus and research on best practice, and a lack of formally approved protocol, clinicians are mostly left to use their “clinical wisdom” when they try to help these children. However, as it was pointedly commented by Zucker (2008a), “one person’s wisdom may be deemed ignorance by another.” (P. 359)

It causes problems for clients as well. Because of these huge variations in the field, a child’s birthplace will determine what kind of help they get. And if the help they are offered does not correspond to what they feel is right, they might travel to other places or to illegally get the help they desire, as pointed out by Giordano (2008).

In our groups the participants were presented with a final vignette that outlines two different approaches to treating children with the diagnosis GIDC. They are asked to reflect on their views of two psychologists, psychologist A and psychologist B. We constructed these two psychologists based on two different psychological approaches that are used currently. As examples of these two approaches we can consider two gender clinics; the gender clinic at the Free University Medical Center in Amsterdam, led by researcher Cohen-Kettenis, and the gender clinic at Toronto’s Centre for Addiction and Mental Health, led by Zucker.

The practice in Toronto attempts to harmonize the body and the mind by changing the mind and behaviors. This is done by behaviorally modifying the cross-gender behaviors, encouraging gender-conforming behavior in the children (Zucker, 2008a). They gently explore the children’s gender identity meanwhile helping them to be comfortable in their born gender and to form and maintain same-sex friendships (ibid.). This approach is close to psychologist A in the vignettes (appendix 1), and will from now on be referred to as the “changing the mind” approach.

In the Amsterdam clinic they do not try to change neither the child’s mind or behavior. They try to help the child in exploring their gender identity without influencing towards a specific outcome, and offer support as the children figure out what they want, making a potential transition as easy as possible for them (Reed et al., 2008) In this clinic they have

administered puberty suppressing drugs quite early to a select group of children with gender dysphoria, as a means of giving these children more time to figure out what they want. This may be followed up with hormone treatment (ibid.). This approach is close to psychologist B in the vignettes (appendix 1), and will from now on be referred to as the “facilitating transition” approach.

3.6.1 The mind/body debate

The approaches of psychologist A and psychologist B differ mainly in the focuses of their interventions. The “changing the mind” approach offers psychological treatment towards the mind, while the “facilitating transition” approach offers a potential medical treatment of the body.

It is important to keep in mind that, in all likelihood, all gender clinics can be categorized on this continuum. In their approach to transgendered clients, professionals will either treat gender variance as more or less a body issue or more or less a mind issue. Note that individual psychologists can choose to take a third approach, in viewing transgenderism as not being a disorder at all (multifaceted view), and focus their intervention at overall psychological wellbeing or self-acceptance in their clients. It is my belief, however, that in gender clinics, professionals are most likely to get clients referred that come to them requesting changes as they are distressed. When facing these clients, the professionals are often forced to choose *what* to target with their interventions. Their model of care will stem from opinions about what could/should change: mind or body.

In essence this is a philosophical mind/body debate. Behind these models of care are ideas about the nature of gender and the relationship between the body and mind. Their intervention choices depends on gender theories as well as thoughts about which path seems less intrusive and more beneficial. There seems to be an underlying notion of a “real” gender that one must uncover, and that it has its source in either in the mind or the body. Wherever the “true gender” lies, be it body or mind, it should not be tampered with. Simplistically speaking, the professional targets the other to adjust it. The “changing the mind” approach might see the bodily gender as the “true” gender and attempt to adjust the mind to correspond. The “facilitating transition” approach sees the “true” gender as something of the mind, and if anything needs change this should be the body.

When our teachers share their thoughts about psychologist A and B they are also, in a sense, debating and formulating views on a mind/body debate. This is interesting by itself, but also holds further significance beyond just describing the group of teachers. Treatments that psychologists offer need to be found reasonable by the children and adults involved. The Norwegian teachers' views are likely to reflect, to an extent, what treatments are likely to be supported by adults and children in this cultural context. The teachers' initial thoughts, their debates and their choice between the two psychologists will be the focus in the following section.

3.6.2 Short synopsis of the results

4 out of 8 groups reached consensus on which psychologist they preferred, all 4 groups agreeing on psychologist B ("facilitating transition" approach). In the remaining 4 groups they did not reach consensus. 1 group was polarized with some supporting psychologist A and others B. More commonly however, was the position that both psychologists were equally right (or equally wrong) and that they wanted something in between the two; this was the case in 3 out of the remaining 4 groups. It was an equally common view that the ideal psychologist depended on the child's age (however, no consensus was made concerning which psychologist was best for younger versus older clients). The groups that did not reach consensus still leaned towards psychologist B, and psychologist A did not reach majority support in any of the 8 groups. We will now take a closer look at the teachers' reasoning; how do teachers describe these two approaches.

3.6.3 Descriptions of the "changing the mind" approach (Psychologist A)

Central arguments for this view on gender variance in children is that since so few will persist in their dysphoria, there is a lot to be gained in exploring alternative reasons for why they are unhappy with their gender. For some children cross-gender behavior might constitute a "fantasy solution" to their problems (Zucker, 2008a). It is argued that potential biological factors might be "predisposing" rather than fixed and that psychological experiences, particularly within a family system, can cause children to choose cross-gender behavior (ibid). This has similarities to how most mental disorders are viewed in terms of causality.

While the body will obviously not change by itself, the mind might, and indeed does for some children. As such some consider the mind to be more “flexible” and one could argue that potential intervention towards change should aim towards the more flexible of the two.

Professionals of this approach are optimistic that therapeutic interventions might help children work through their dysphoria by exploring gender and by behavior modification. While younger children are more malleable, gender identity becomes increasingly fixed with age, to a point where there is little evidence that psychotherapeutic intervention has any effect at all (Zucker, 2008a; Zucker, 2004). Therefore, they argue, we can and should to change the mind while the child is still young. One approach is with the use of behavior modification. This is by far the most controversial part of this approach. While behavior modification was quite commonly used in the 60’s it has often been one of the greatest sources for controversy (Diamond, 2004). In addition there are testimonies from transgendered persons that describe the damaging effect this procedure can have on some individuals (Diamond, 2004). However there are also indications that in some cases this method has been beneficial (Zucker, 2008a).

The goals of this approach is that if one might reduce the dysphoria by changing the mind we both lessen the distress, lessens the social ostracism; reduce degree of psychiatric comorbidity and reduce the need of having to go through invasive and costly surgery (Zucker, 2004).

Support of the “changing the mind” approach.

Amongst our teachers many individuals did support the psychologist based on this approach, at least in parts. The arguments were broadly in one of these three categories: 1) viewing this therapy as a more realistic solution, 2) viewing it as a more cautious intervention 3) viewing the therapy as one offering relief *now*.

In the first group of arguments some state that psychologist A’s take on this feels more “realistic” as an option. As mentioned earlier, teachers did not convey a lot of knowledge about puberty suppressive drugs or similar hormone treatments, so it might that they see the only possible change as an actual surgical intervention. If so they would naturally assuming that children with gender dysphoria will indeed have to wait many years before any transitioning can occur and show a great deal of patience. The arguments went that since the children will not be able to change their gender in many years anyway, they will have to try to be comfortable in their born gender to make living tolerable (Participant G, Focus group 2). This is something they will *have* to work on. They will have to cope with this discrepancy

between their bodies and their mind, and as such psychologist A offers a solution for this (Participant Z, Focus group 6).

Another argument in this category was stating that you cannot “truly” change gender (Participant X, Focus group 6), which is a way of seeing “true” gender as something that resides in the body. In our western society the question of gender is often seen as identical to which type of genitals your body was born with (Witten et al., 2003), and by this argument your gender identity must adjust to fit it. Similarly some argued that no matter how anyone views it the child will encounter many people with the same view as psychologist A (namely that their “true gender” lies in their body), and that the children will have to adapt to. Realistically they’ll have to adjust to the confines of traditional gender categories, where most will see them as their born gender. Hence, it’s argued, they will have to adjust either way (Participant W, Focus group 5). Though voiced with considerable empathy, this is the same gender model, only here it is attributed to society’s beliefs instead of oneself. Underlying this is a certain degree of pessimism; you have to give up your perceived gender identity, because society at large will never acknowledge you as a “real” female.

For teachers that agreed with the argument of psychologist A being more “realistic” it might be because the dysphoria in itself is something that teachers found hard to relate to. Given the rarity of this degree of gender variance, the gender variance itself might be part of what’s seen as “unrealistic”. And this was in fact stated in a few groups (Focus group 1 & Focus group 4). It is understandable considering most of these adults (statistically speaking) will not have questioned their own fundamental gender identity. For some it might seem intuitively right that the child’s thinking is what needs to change, and that our perception can remain the same

The “changing the mind” approach offers a “down to earth” way of dealing with the gender dilemmas for the teachers that agreed with this thinking. It deals with here and now in a situation unlikely to change for years. At this point in the children’s lives it is all about waiting for the age where they can decide things, and getting along with their peers. Participant Q (Focus group 4) addressed the imagined vignette child like this: “You have to realize that this is quite different and you might get some comments. We will try to help you any way we can, but you might have to develop somewhat tougher hide than other children, right?”

In the second group are arguments that see the “changing the mind” approach as more cautious or conservative and therefore prefers this approach. Psychologist A doesn’t really

open for the children changing gender, and rather encourage that they “stay as they are” for now. There are many reasons why teachers might prefer that. Quite a few saw it as too radical to say anything that supports the children perception of own gender. “I think it’s a little too early. 11 years and supposed to encourage him to pursue that line of thinking? [...] Should he really be encouraged to do that even as an 11 year old?” (Participant Ø, Focus group 6).

Psychologist A is here seen as analogous to a break on a runaway vehicle, slowing down something that might possibly get out of control and lead to undesirable outcomes. It is interesting to look at where this vehicle is headed and exactly why it is desirable to slow it down. One can speculate what the dangerous endpoint might be in the minds of these teachers.

They might be worried about the outcome of SRS, which is a potentially dangerous surgery that you would not want to have to go through unless absolutely necessary. Or the danger might be a future as a transsexual, deviating from the typical. And if so, if transsexual outcome is indeed seen as undesirable, is this because they have prejudices (i.e. transsexual adult is a less good outcome than being “normal”), or is it based on concern and empathy (i.e. the hardship and social sanctions transsexuals face)? This would not be unique to teachers. In the past, avoiding the “undesirable” outcomes of homosexuality, transvestisism or transsexuality has been a main goal for many professionals (Bryant, 2006). Indeed Zucker is have claimed that the prevention of transsexualism as an adult constitute sufficient justification for therapeutic intervention because of the ostracism they face (Zucker, 1990, P 30).

Lastly but not least; this “break” might be hindering the impact of a potential regret later. What if they change their minds after for instance having done SRS? Could they get stuck in a gender role that they find they do not really want?

Both in reply to this question as well as others, there was little evidence pointing towards teachers being particularly guided by prejudice, although this might be obscured by social pressure. From what the teachers expressed throughout the focus group as main concerns, I do believe that potential regret was the primary concern, above hindering a transgendered outcome. Many teachers said that if there was any doubt in the child (Participant G, Focus group 2), if this might be a phase (Participant K, Focus group 3), or if the child was simply far too young (Participant E, Focus group 2), then the “changing the mind” approach (psychologist A) could be the right choice, and they made these the conditions under which they would pick A. I believe that they saw what they considered a

more conservative option as a safety valve against possible regret and harm if the child grows out of it.

The most universally agreed upon support to the “changing the mind” approach regarded its focus on constructive measures; making children comfortable in their current bodies and helping them make friends with same-sex peers. The description of psychologist A was most likely to be appreciated based on the removal of conflict and distress. While the second point acknowledges that distress to a large extent comes from the surroundings and needs to be removed, the first point (comfortable in own gender) also implicates that the gender identity of the mind is not as “true” as the gender of the body. The gender of the mind is viewed as more flexible and can change.

The appeal of these two elements from the “changing the mind” approach, are easy to see. It seemed a general agreement that if one were to actually *successfully* make these children comfortable in their born gender and *also* treated well by their peers then the problem would be solved. The fact that this could occur *earlier*, time wise, than the potential relief after fully transitioning seemed also to play an important role. In theory this goal would be obtainable right now (if it is indeed obtainable), and would not require a distressed child to wait for years for the work to start. The participants advocating for psychologist A’s views approached these points as something lacking in the description of psychologist B (modeled after Cohen-Kettenis). In the occasions where groups wanted to find a middle ground between psychologist A and psychologist B this was the most likely point to be brought from the “changing the mind” approach.

Criticism of the “changing the mind” approach

As the observant reader might note; no one directly supported behavioral modification aspect. Only two teachers hesitantly stated that this might be an alternative; one saw it as an option for changing the cutting behavior (Participant Æ, Focus group 6), which is somewhat different. Another said it might help if the child was “just acting out” (Participant Y, Focus group 6), meaning that there was no true dysphoria. While some did approve of Zucker’s encouragement of gender-typical behavior, none directly supported *discouraging* the child from acting out cross-gender behaviors.

As we turn to the critique of the “changing the mind” approach, we find behavior modification at the core of what made the majority of teachers skeptical. In fact it seemed all critique revolved, in some way or another, around this point. Many asked questions about

what kind of “correcting” this would entail, some found the description provoking (Participant AD, Focus group 8). The method of behavior modifying seemed to scare many away from choosing psychologist A, also amongst those that were otherwise positive towards the approach. The most strongly worded opposition expressed that they believed it to be potentially traumatizing or even fatal (amongst others: Participant AG, Focus group 8; Participant C, Focus group 1; Participant H, Focus group 3). The justification of their skepticism was most commonly that it was wrong against the children in question. Teachers said that psychologist A demanded too much adjustment from the child (Participant AG, Focus group 8; Participant J, Focus group 3), was not taking the child’s views seriously (Participant AG, Focus group 8; Participant P, Focus group 4) and was pathologizing the child (Participant P, Focus group 4). One teacher pointedly said that in this approach the child is really superfluous, as the outcome has already been decided (Participant H, Focus group 3). She went on to describe the psychologist as closed off towards the child. As a mirror reflection of these arguments we see the outline of several core ideas on how they feel children ideally should be treated by professionals. We may also interpret this in view of the mind/body debate. The mind of the child *must* be taken into consideration, must be seen and validated. The therapist should not close her/himself off towards the experienced gender identity within the child.

Amongst the critique some also took broader societal perspectives, often associated with the misuse of power. Several compared this to religious indoctrination towards gay people (Participant AH, Focus group 8; Participant D, Focus group 1; Participant P, Focus group 4) or labeled it brainwashing (Participant U, Focus group 5; Participant AE, Focus group 6; Participant B, Focus group 1; Participants E & F, Focus group 2). This comparison suggests that they see therapist as using behavior modification to “force” the child’s mind into changing.

Some suggested that this approach, by separating strictly between gender appropriate (“right”) versus gender non-appropriate behaviors (“wrong”), contributes to rigid gender roles (Participant P, Focus group 4), making conditions harder for the gender variant minority group. In focus group 7 they disputed psychologist A with scientific references; referring to the case of John/Joan (Colpatino, 1997; Asscheman, 2009) and claiming this treatment doesn’t correspond to empirical evidence of biologically based gender identity (Participants AC & AD). While this is a topic still debated it is enough to note that their conviction, of gender identity as biologically based, made them completely renounce the “changing the

mind” approach; objecting strongly to attempts of changing the child’s mind. It could seem that for conditions that you are “born with” there is a lot more tolerance (Ehrbar, 2010). It adds to the perception of the clients perceived gender identity being “real”, and in this case it makes the participants view it as something that should not be changed. Also interesting is their perception of a general scientific consensus for this. Other teachers displayed a similar idea by characterizing psychologist A as “old fashioned”(Participant AH, Focus group 7; Participant AH, Focus group 8), again indicating a belief that science or society has moved past this approach. This is not too far from the truth, a wide range of specialists are equally skeptic towards the “changing the mind” approach. In fact countless articles state that the goal of therapeutic interventions towards GIDC children should not be to change their cross-gender behavior (i.e. Di Ceglie, 2008; Bryant, 2006; Benestad, 2010). As one of the professionals using behavior modifying techniques, Zucker (2004) retaliates, claiming that allowing cross-gender behavior can be a reinforcement of said behavior. In other words: by allowing it you are also influencing the child’s mind and possibly perpetuating the gender dysphoria.

3.6.4 Descriptions of the “facilitating transition” approach (Psychologist B)

The “facilitating transition” approach is skeptical towards trying to force a change in the minds of gender variant children. If any interventions have a goal of inducing change, it is focused on changing the body. However this does not apply to all cases, and only comes after lengthy psychological exploration and testing. In the cases where they start physiological interventions, reversible interventions precede irreversible ones. Puberty suppressant drugs (GnRHa) can be administered to clients as young as 12 years old in some clinics, depending on national legislation and parental consent (Reed et al., 2008). Practitioners within the “facilitating transition” approach argue that administering a puberty suppressor is a reversible treatment, with no findings of adversary side effects so far (Giordano, 2008). It is argued that *not* administering such drugs is also an intervention (Reed et al., 2008; Giordano, 2008). The side effects by doing this, they argue, are far more worrying. Going through the puberty of their biological gender can be very distressing, and will result in irreversible bodily changes. Because of this, early treatment is generally preferred, following guidelines from WPATH (WPATH, 2008).

On a psychological level the approach stresses the importance of support and acceptance. Cohen Kettenis observing that the clients that had supportive parents and surroundings, and who knew from childhood that they could have puberty delaying treatments and cross-sex hormone treatment do not remember experiencing distress (Cohen-Kettenis et al., 2008). For these children the “facilitating transition” approach seems to have contributed to normalization, by validating the child’s perceived gender identity and conveying possibilities for physical change of the body.

The “facilitating transition” approach faces some tough challenges. A key assumption is that when gender dysphoria is persistent, interventions should target the body (hormonally or surgically) rather than the mind, but what if one irreversibly alters the bodies of an individual who later regrets it? When it comes to treating children this is indeed a considerable challenge, since within this particular age bracket the majority will desist (Drummond et al., 2008).

How do they then face this challenge? Uncovering biological basis or predictors for gender variance would potentially be an important tool in predicting desistance. There is increasing evidence that gender variance is not caused by choice or environmental factors alone (Cohen-Kettenis et al., 2008). This is supported in a study by Kruijver et al. (2000). They registered post mortem findings in brains of transgendered persons, which showed opposite sex characteristics in the stria terminalis and the limbic nucleus. While studies like these are promising, there are no biological tests (as of yet) that can predict with certainty which individuals that are likely to remain gender variant. It therefore becomes clinician’s job, through a lengthy process, to identify the children with GIDC that are likely to *remain* dysphoric (Cohen-Kettenis et al., 2008) and to offer medical treatment only to these children.

Support of the “facilitating transition” approach

Amongst our teachers support for psychologist B was prominent in the replies. Generally this support fell into the following two categories: 1) viewing the approach as having a better mentality towards human nature and 2) viewing it as more likely to give a good outcome.

Within the first category teachers basically expressed that psychologist B’s mentality towards human nature appealed to them. It was described as feeling “right”, “natural”, “more open” and “flexible” (Participant E, Focus group 2; Participant H, Focus group 5; Participant Å, Focus group 6; Participant AG, Focus group 8). Teachers expressed a belief that as a result

the child's wishes would be heard and taken seriously (Participants AE & AD, Focus group 7; Participant P, Focus group 4; Participant E, Focus group 2; Participant J, Focus group 3). In the minds of these teachers, embracing the client's reality seemed likely to bring about a better outcome, as opposed to forcing your own views down on it. Similar attitudes are expressed in the literature by Bockting (2008), Benestad (2010), Di Ceglie (2008) and Diamond (2004) in articles about gender dysphoria in children. Benestad (2010) expresses that he believes the strongest sense of gender is in the mind of each individual and that it follows that none other than the client can be in a position to know best. As teacher commented "you have to live in relation to the world around you, but you have to be able to live with yourself as well" (Participant O, Focus group 4). This is interpretable as a belief that in order to be healthy and happy, being "true to yourself" has to have priority over adjusting to social expectations.

One of the teachers gives the following description:

And then I think I would have chosen psychologist B [...] A human should be happy based on their body and their needs, and I think I would let him go to B for a long while. "What..? What do you want? Wh..? How do you feel?" Ok, and then we wait for a few months and.. Like.. "Yes, how is this working out?" (Participant E, Focus group 2)

This teacher describes a lengthy process of asking the client for its input, exploring with the child and readjusting yourself according to the replies. This is a far cry from behavior modification with the "changing the mind" approach. She also expresses a core belief about finding happiness based on your own individual needs; the client knows best, "nobody can dictate what is right for you" (Participant J, Focus group 3). Similar statements of individualism found great resonance throughout most groups. In focus group 7 they commented on a shift in mentality in the schools, with regards to how differences are perceived. Participant AE (Focus group 7) explained that she had felt there was a shift from the motto of "everybody is the same" to "everybody is different, but that is ok". If so this draws parallels to the growing influence of individualism in society at large, as well as client-centered therapy's firm footing in the field of clinical psychology. These statements indicate a core value in thinking, namely that no one from the outside can dictate what or who you are. Being "true to yourself", is to accept and embrace the gender identity of your mind, setting it above your body's gender attributes or other people's opinions of you. "True" gender is found within the individual mind.

The other main group of supporting arguments dealt with the probability of a beneficial outcome, which was linked to the previous point. A majority of the teachers viewed the “facilitating transition” approach as more likely to produce a successful long-term outcome and frequently referred to it. Teachers deemed it likely that, as a result of this treatment, the client would get better self-esteem and experience less tension (Participant AD, Focus group 7). As one example, participant AH (Focus group 8) explained her reasons to believe in a good outcome. She described the “changing the mind” approach (psychologist A) as “covering over [the problem]” and forcing clients to “hide their true impulses”, which would be still bubbling under the surface, and which would later cause problems when they could be repressed no longer. “Eventually, the bubble must burst” (Participant AH, Focus group 8). Meanwhile she felt that the “facilitating transition” approach (psychologist B) would dig deeper and let these children think, talk and explore their own feelings towards this, resulting in less inner conflict.

The teachers themselves named two important reasons that they felt this approach would have a better outcome; the child getting social support and the child accepting oneself. This is closely linked to the mentality towards human nature. The importance of these two factors is supported by Bryant (2006), as well as a significant part of the scientific articles published in the latest decade. Bryant states that the greatest promise for the future comes from interventions that are helping children and their families cope with stigma instead of trying to change their behavior.

Criticism of the “facilitating transition” approach.

As we turn our attention to the critique of the “facilitating transition” approach, there are mainly 2 reasons that made several teachers choose a middle ground between the two approaches, and two teachers (Participant Y & Ø, Focus group 6) support the “changing the mind” approach. 1) the approach is too “radical” and 2) the approach has less focus on the environment. Both points can be related to respectively the second and third argument in support of “changing the mind”.

The first argument is that the teachers viewed the “facilitating transition” approach as too “liberal”. As previously mentioned, teachers seemed to regard psychologist A as more of a “break” on transitioning. Psychologist B was not perceived this way. The “facilitating transition” approach advocates early treatment in the cases where children are deemed to be good candidates for cross hormone treatments. However, as previously mentioned there is

always the possibility of administering treatment on individuals who later regret it. The “changing the mind” approach argues that since there are few reliable predictors for lasting dysphoria, they would not encourage any form of transitioning this early in life. As such there is a real difference where psychologist A’s approach is per definition more “cautious”. Noting this, quite a few teachers questioned whether psychologist B was in fact a little *too* tolerant towards transitioning. “Either you’re getting manipulated into not expressing your feminine side, *or* you’re rushed into changing your gender. It’s very either/or [...] they [the two approaches] are very extreme in different directions” (Participant B, Focus group 1)

These teachers were doubtlessly sharing the same worries about false positives. Many focused on the low age of the child and the probability of it being a phase (Participants Ø & AA, Focus group 6; Participants B & D, Focus group 1). Some teachers questioned whether one can truly know what one wants at 11 years old (Participant W, Focus group 5; Participant B, Focus group 1). (For further reading, see: “Validity of the child’s opinions”.) They also worried that they might feel pressured later to stick to their cross-gender identification. They warned against presenting sex reassignment as some sort of easy solution to the child, and wanted to convey the realism of the challenges ahead (Participant B, Focus group 1; Participant Q, Focus group 4).

As we turn to the second argument, this addresses in detail parts of the description of psychologist B. In particular it lacked psychologist A’s explicit goals of helping children be comfortable in their gender and achieving same-sex friendships. Since many teachers liked these points, some teachers wanted a middle ground in order to include them, possibly to merge the two psychologists into one “perfect” one (Focus group 1; Focus group 5; Focus group 6). It can seem almost a paradox that the goal of making the child comfortable in their born gender can coexist with a wish of accepting the client’s wishes and reality. Several explanations can be offered of why this is not seen as contradictory by the teachers. One such explanation is that making comfortable, after all, does not equal accepting. The goal of making the client comfortable in their biological gender does not necessary entail refusing to accept that their perceived gender is the “true” one (Participant E, focus group 2). Much in the same way we can make someone who is ill feel comfortable, without thereby insisting that their condition is a preferred state that they ought to remain in.

The description of psychologist B focuses less on coexisting with peers and adjusting to the environment. This can be seen as is problematic. Even though the teachers wish for the child to be accepted with their perceived gender identity they also view it as unlikely that they

will be able to go through this alone. As John Donne wrote, “No man is an island”. They need to be accepted by other children, not just find the acceptance within themselves. For this to happen they will probably have to adjust to them.

Is the teachers’ critique addressing something that truly lacks with the “facilitating transition” approach of psychologist B? Does this approach do enough to mediate between the child and its environment, or does it neglect to consider the social context? By stressing the importance of having support, and by working directly with the parents, the approach does recognize the importance of the social surroundings. In an article by Reed et al. (2008) it is advised that younger clients should not publically change their gender role until they reach adolescence. This is because so many grow out of it, and also so as not to evoke too many negative responses from the environment. This fits in nicely with compromises that several teachers suggested for the child; advising a pragmatic separation of private self and official self. In order to reduce victimization the teachers proposed that the gender variant child might tone down cross-gender behavior at school and instead use their home as an arena to explore cross-gender behaviors more freely (Participants A & B, Focus group 1; Participant AF, Focus group 7; Participant AG, Focus group 8).

The ultimate question here seems to be: where does the balance go between being “true to yourself” but at the same time “fitting in”? Now, in an ideal world these children should not have to compromise nor “hide” who they are. However, from the perspective of a teacher witnessing bullying in an actual class, it raises some dilemmas and challenges. Participant Y (Focus group 7) gave a frustrated description of a pupil who would act in a way that provoked peers and that would consistently result in negative feedback which made him distressed. She saw this as a challenging dilemma; if he were to tone down these behaviors he would experience less distress, but at the same time not be “true” to himself (Participant Y, Focus group 7).

Many teachers worried about the social consequences with “coming out” in such a hostile environment (Participant B, Focus group 1; Participant Q, Focus group 4). In one focus group (Focus group 1) the topic of social context was particularly prominent as theme. This group saw it as especially important to recognize that different social contexts offer different penalties for stepping out of traditional gender roles. They pointed out that in some cultures this might have potentially life-threatening consequences. The child might lose support from its family, potentially being outcast from it (Participant A & C, Focus group 1). They pointed out that gender variance can in fact be very difficult for the surroundings accept

and relate to (Participant D, Focus group 1; Participant Y, Focus group 6). As a consequence the group stressed the importance of mediating between the child and its immediate surroundings, and they cautioned against a naïve encouragement of “just being yourself” (Participant A & D, Focus group 1).

In settings like these, with highly hostile surroundings, some see psychologist A’s attempts of reconciling the child with its surroundings and helping it develop same gender friendships as highly constructive. Consequently it seems reasonable that some question the apparent lack of this focus in the “facilitating transition” approach.

3.6.5 Merging views

As we return to our question of what approach seems plausible to the teachers it seems clear that if they had to choose, the majority would support the approach of “facilitating transition”. The teachers express beliefs that “true” gender lies within the mind. The gender non-conforming behavior in the vignettes is in most cases seen as an expression of innate traits, not as a choice or something that is learned.

Merging the two psychological approaches we can see the outline of what they consider the ideal approach. They wish for respectful understanding and good dialogue between therapist and child; that the therapist is someone open-minded that the child can talk to and explore topics of gender with. The child’s perceived gender identity is to be taken seriously, without attempts to influence it. They reject the notion of somebody influencing the children on what to do or how to act, and do not support the use of behavior modifying techniques. They wish for a therapist that will let these children express themselves freely within flexible gender roles. They want the process to be slow, buying as much time as possible so the children are as certain as they can be before transitioning. The children should get substantial help and advice on how to navigate in their particular social surrounding in a way that decreases distress and bullying, generating as much social support as possible.

For Norwegian psychologists, these views indicate what type of psychological approach is likely to be accepted within this cultural context. The teachers’ descriptions are indicative of what kind of psychological support they hope for, what kind of psychological intervention they would find plausible, and would want to support. In fact it can be said to indicate what kind of psychological contribution would encourage them to refer the child to a psychologist at all.

4 Conclusions

We will now examine the relevance this study has for clinical psychologists. To ensure the support of adults and children towards psychological interventions, it is crucial that therapeutic approaches are found plausible within these individuals' gender models. This can in fact determine whether they contact a psychologist at all. Our participants are likely representatives for adults who work with children, and in this section we will be examining the focus groups' gender models, as well as their attitudes towards therapeutic approaches and working with psychologists.

Gender was most commonly viewed as being of the mind, rather than of the body. The teachers debated gender variance in light of both binary and multi-faceted models of gender, with a tendency of binary models being challenged and multi-faceted models winning ground. It was seen as an innate core "truth" that one needs to uncover, not change. Finding and accepting one's gender identity was seen as healthy, and as a necessary step towards self-actualization. Therapeutic approaches that focus on self-actualization and healthy emotional development of these children are therefore likely to gain adult support.

When talking about lowering distress in gender variant children, teachers did not express beliefs that distress is inherent in gender variance, but focused on the environment's role in adding to it. Reducing distress was defined as the grown-ups responsibility. They saw it as important that the gender variant child had access to adults that were supportive, that validated child's opinions and that they could talk openly to. Some psychological approaches see gender variance as something "disorderly" in the child's mind, that needs to be "fixed", and this seems to impact the face validity of the treatment negatively. Instead psychological approaches need communicate acceptance and supportiveness towards young gender variant clients.

To lower distress in a school setting, teachers saw it as important to work actively towards changing attitudes in their pupils; teaching tolerance towards diversity directly and by example. Our analysis revealed that reports of high feelings of competence were associated with behaviors that are likely to enhance emotional wellbeing and increase social acceptance of gender variant children. Similarly, reports of low feelings of competence were associated with behaviors that are likely to increase distress and social ostracism. When working with teachers and adults it is vital that psychologists help build feelings of competence, if they

wish these people to have positive influence on the gender variant children's emotional wellbeing.

To reduce distress, teachers stressed the importance that gender roles were flexible, with gender variance being clearly visible in society as large. When possible, it is beneficial that psychologists work towards the broad visibility of gender variance in the media, and that we promote flexibility in gender roles rather than trying to ensure gender conformity in gender variant people.

When talking specifically about working with psychologists, the teachers themselves highlighted that they wanted the therapist to be open, with information going in both directions. High feelings of competence were again a positive factor; associated with more optimistic attitudes towards working with a therapist, as well as higher levels of involvement from the teachers.

Addressing psychological approaches, teachers expressed skepticism against the use of behavior modifying techniques in the "changing the mind" approach; believing this to be harmful. This applied whether they displayed a binary or a multi-faceted gender model. They were more likely to support interventions that did not try to influence the perceived gender identity of these children, but that encouraged exploring. If something was to be changed it would have to be in accordance with the child's true wishes. The "facilitating transition" approach was generally supported, however teachers were skeptic towards early transitioning, expressing that a potential transition process should progress as slowly as possible, buying the child time. They cautioned against publically "coming out" or making long term commitment to a gender at a low age, in case of later regret. Skepticism against transitioning might have been enhanced by the fact that they did not express knowledge about puberty suppressing hormones as a treatment option. Teachers stressed the importance of considering cultural and social contexts, as well as aiding the child in successfully adapting to these.

These are some of the considerations that psychologists should have in mind interacting with gender variant children their families and surroundings. As a final note I would like to end this paper with the last advice given to me, as a future psychologist, by a participant on the very last focus group:

"I have been teaching [...] for many years and this was absolutely not a topic during my education or my job, until today. This kind of topic is one I wish I had encountered 15 years ago and.. I think it's *good* that it is addressed and that we can focus on expanding the term "normality" in a constructive way" (Participant AH, Focus group 8)

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6 Appendix

6.1 Appendix 1

6.1.1 Intervjuguide (på norsk)

Introduksjon:

Hvem er jeg?

Navn, student ved psykologisk institutt, hovedoppgave.

Rammene:

Gruppemøtet vil vare 1 time. Det blir tatt opptak av samtalen så jeg ikke glemmer noe, dette skriver jeg inn, all personlig info slettes og makuleres innen 2012.

Det er fint om dere prøver å snakke så tydelig som mulig så det er lettere å høre hva som sies på opptaket senere og at dere unngår å avbryte hverandre.

Anonymitet:

Jeg har taushetsplikt, ingen av deres navn vil bli brukt i oppgaven

For å ivareta anonymiteten blant gruppemedlemmene ser jeg helst dere ikke bruker navn på andre gruppemedlemmer dersom dere snakker om temaene fra i dag med noen utenfor gruppen, hva synes dere om dette?

Kunne vi ha en avtale om at vi sier det sånn?

Dere trenger ikke å snakke i en bestemt rekkefølge, hvis du har noe på hjertet- si det.

Det er viktig å få høre hva slags meninger hver og en av dere har.

Fordi vi har begrenset med tid kan det hende jeg stopper dere og styrer samtalen litt.

[Leverer ut samtykkeskjema, samle inn samtykkeskjema.]

Vignetter:

Innenfor kjønn er det stor variasjon av maskulinitet og femininitet, vi kommer til å fokusere på barn som er atypiske i forhold til kjønn de er født med. Det vil si gutter med stor grad av femininitet eller jenter med stor grad av maskulinitet.

Først vil jeg gi dere en kort historie å lese, så vil jeg at dere skal dele deres umiddelbare tanker med hverandre. Deretter spør jeg et par spørsmål. Så gjør vi det på nytt med en annen kort historie. Jeg ønsker at dere skal snakke fritt med hverandre om hva dere tenker i forhold til historiene.

[Levere ut vignette 1, “Oscar”]

Jeg vil gjerne at dere snakker fritt med hverandre om deres umiddelbare tanker når dere har lest denne historien.

Spørsmål:

Nå har jeg et par spørsmål:

Hva ville dere si til dette barnet?

Hva slags følelser ville dere ha i forhold til dette barnet, hvilke følelser får dere når dere hører historien.

Hva ville dere gjøre som lærere? [spørre individuelt].

Ville dere som gruppe klare å komme frem til en felles beslutning?

[Levere ut vignette 2, “Tom”]

Jeg vil gjerne at dere snakker om deres umiddelbare tanker når dere har lest denne historien.

Spørsmål:

Nå har jeg et par spørsmål:

Hva ville dere si til barnet?

Hva slags følelser ville dere ha i forhold til dette barnet, hvilke følelser får dere når dere hører historien.

Hva ville dere gjøre som lærere? [spørre individuelt].

Ville dere som gruppe klare å komme frem til en felles beslutning?

[Levere ut vignette 3 “Psykolog A og B”]

[les:]

Det jobber 2 psykologer som begge er spesialiserte på denne typen problematikk, men som har veldig forskjellige tilnærminger i sitt arbeid.

“Psykolog A har denne innfallsvinkelen: hjelpe ungdommen å bli komfortabel i forhold til biologiske kjønn, hjelpe med å korrigere adferden så dette lettere kan skje og den lettere får venner blant eget kjønn.

Psykolog B har denne innfallsvinkelen: hjelpe ungdommen med å finne ut hva den virkelig ønsker, og dersom den ønsker å leve som det annet kjønn er målet å gjøre overgangen så lett som mulig for den.”

Jeg vil gjerne at dere snakker om deres umiddelbare tanker.

Spørsmål:

Hva er den beste tilnærmingen på lang sikt?

Hvis et av barna vi leste om skulle bli sendt til en psykolog:

Hva tror dere ville skje hvis psykolog A jobber med barnet?

Hva tror dere ville skje hvis psykolog B jobber med barnet?

Ville dere som gruppe klare å komme frem til en felles beslutning?

Avslutning

[Takke for deltakelsen, oppfordre til spørsmål eller kommentarer. Oppgi kontakt informasjon (tlf. nr og e-mail adresse)]

6.1.2 Interview guide (translated to English)

Introduction:

Who am I?

Name, student from the psychological institute, master thesis.

Structure of the meeting:

The group meeting will last for 1 hour. The conversation will be recorded so that I don't forget anything, this will be written down, all personal information will be deleted and maculated within 2012. It would be nice if you all try speaking as clearly as possible so that it is easier to hear what is being said on the recording later, and that you avoid interrupting each other.

Anonymity:

I am sworn to confidentiality, no names will be used in the thesis.

To maintain anonymity among group members i would prefer if you do not use names on the other teachers if you talk about today's topics with anyone outside the group, what do you think about this?

Could we have an agreement to do it this way?

You do not have to speak in any particular order, if you have something to say- say it.

It is important to hear the opinions of each and every one of you.

Because we have limited time i might stop you and direct the conversation.

[Hands out consentform, gathers consentforms]

Vignettes:

Within gender there are huge variations of masculinity and femininity. We will focus on children that are atypical in regards to their born gender. That means boys with a high degree of femininity or girls with a high degree of masculinity.

I will first give you a short story to read, then i want you to share your immediate thoughts with eachother. After this I will ask a couple of questions. Then we will repeat this with another short story. I want you to talk freely with eachother about your thoughts in regards to the stories.

[Hand out vignette 1, “Oscar”]

I want you to talk freely to each other about your immediate thoughts once you have finished reading this story.

Questions:

I now have a couple of questions:

What would you say to this child?

What kind of feelings would you have towards this child, what kind of feelings do you get when you hear the story?

What would you do as teachers? [Ask individually]

Would you as a group be able to reach a joined decision?

[Hand out vignette 2, “Tom”]

I want you to talk to each other about your immediate thoughts once you have finished reading this story.

Questions:

I now have a couple of questions:

What would you say to this child?

What kind of feelings would you have towards this child, what kind of feelings do you get when you hear the story?

What would you do as teachers? [Ask individually]

Would you as a group be able to reach a joined decision?

[Hand out vignette 3 “Psychologist A og B”]

[read:]

There are 2 psychologists, both specialized in this kind of problematics, but that have very different approaches in their work.

“Psychologist A has this approach: help the child to become comfortable in regards to its biological gender, help to correct the behavior to make this easier, and to help it get friends within its own gender.

Psychologist B has this approach: help the child to find out what it really wants, and if it wishes to live as the other gender the goal is to make the transition as easy as possible for it.”

I want you to talk about your immediate thoughts.

Questions:

What is the best approach in the long term?

If one of the children that we read about were to be referred to a psychologist:

What do you think would happen if psychologist A works with the child?

What do you think would happen if psychologist B works with the child?

Would you as a group be able to reach a joined decision?

Ending

[Thank them for participating, encourage questions or comments. Hand out contact information (phone number and e-mail adresse)]

6.2 Appendix 2 (vignettes)

6.2.1 Vignette 1 (“Oscar”)

In Norwegian:

“Oscar er 11 år, og har i følge foreldrene alltid vært veldig feminin. Han sier at han egentlig er en jente. På hjemmefronten har Oscar ofte lånt svært feminine klær av søsteren, på skolen kler han seg noe mer kjønnsnøytralt. Han mobbes av medelevene, det har vært tilfeller hvor han har blitt fysisk trakassert. Oscar sier han er ulykkelig, han gråter mye og har blitt mer og mer innesluttet. Det har også blitt kommet for dagen at han kutter seg.”

Translated to English:

“Oscar is 11 years old, and has, according to parents, always been very feminine. He says that he is really a girl. At home Oscar has often borrowed very feminine clothing from his sister, at school he dresses more gender neutrally. He is bullied by his peers; there have been instances where he has been physically harassed. Oscar says he is unhappy, he cries a lot and has become more and more reticent. It has also been discovered that he cuts himself.”

6.2.2 Vignette 2 (“Tom”)

In Norwegian:

“Tom er 11 år og har alltid vært feminin, han misliker typiske gutteting og foretrekker feminine klær. Han sier han er ei jente. Foreldre ser det egentlig som ganske uproblematisk, gutten virker relativt veltilpasset i sitt miljø; han har et par gode jentevenner som han leker med. Han er i ferd med å gå inn i puberteten og uttrykker misnøye med hver kroppslige forandring. Tom har eksplisitt uttrykt ønske om å endre navn.”

Translated to English:

“Tom is 11 years old and has always been feminine, he dislikes typical boy-stuff, and prefers feminine clothing. He says he is girl. The parents view this as fairly unproblematic; the boy seems relatively well-adjusted to his environment; he has a couple of good female friends that he plays with. He is about to enter puberty and is expressing discontentment with every bodily change. Tom has explicitly expressed a wish to change his name.”

6.2.3 Vignette 3 (“Psychologists A and B”)

In Norwegian:

“Psykolog A har denne innfallsvinkelen: hjelpe barnet å bli komfortabel i forhold til dens biologiske kjønn, hjelpe med å korrigere adferden så dette lettere kan skje og den lettere får venner blant eget kjønn.

Psykolog B har denne innfallsvinkelen: hjelpe barnet med å finne ut hva den virkelig ønsker, og dersom den ønsker å leve som det annet kjønn er målet å gjøre overgangen så lett som mulig for den.”

Translated to English:

“Psychologist A has this approach: help the child to become comfortable in regards to its biological gender, help to correct the behavior to make this easier, and to help it get friends within its own gender.

Psychologist B has this approach: help the child to find out what it really wants, and if it wishes to live as the other gender the goal is to make the transition as easy as possible for it.”